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ABSTRACT

This collection of five case studies reveals how screening programs for preschool and kindergarten children are currently being implemented in the Commonwealth of Massachusetts. Programs in a variety of communities--large and small, rural, urban and suburban--are portrayed. The screeners interviewed were chosen in part because they also vary in the nature of their background and experience and in the way their positions are structured. Some are responsible only for the screening of 3- and 4-year-olds; some also are responsible for kindergarten screening. The first case presented is the most complex and complete, while others highlight variations and special aspects such as screening for speech and language problems and bilingual screening. In each case topics such as planning, outreach, organization and procedures, instruments, reporting, and the screener's role are discussed. In order to clarify issues related to screening, educational evaluations and intervention programs are discussed briefly. A commentary in which special problems and issues are discussed follows the five case studies. The appendix provides a list of screening instruments, including addresses of publishers. (Author/RH)

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CASE STUDIES OF SCREENING PROGRAMS FOR YOUNG CHILDREN

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PREFACE

This is a collection of five case studies representative of how screening programs for young children are currently being implemented in the Commonwealth of Massachusetts. Now that all communities are mandated to provide such screening, a task new to many school systems, persons who are responsible for these programs must cope with increasingly complex demands. Recognizing this new situation, the Early Childhood Project (funded by the Division of Special Education of the Massachusetts State Department of Education and by the Bureau of Education for the Handicapped) began to provide inservice training programs. In 1978 Summer Inservice Institutes were offered in screening and in assessment. These Institutes were designed to provide participants with the tools for organizing, building, and improving programs in their communities. Follow-up meetings for each Institute were held at intervals during the school year.

Participants reported that they benefited greatly from the opportunity to learn about how their colleagues were implementing programs. The Early Childhood Project therefore commissioned this series of case studies of persons who had attended a Summer Inservice Institute on screening and who had major responsibility for their local screening programs. These "screeners"were asked to share problems and solutions, issues and choices, in order to provide "flesh and blood"models to supplement the relevant regulations.

The case studies represent the current "state of the art"; they are not necessarily ideal programs. Indeed, in almost every case, there are flaws in the screening programs, including instances of non-compliance with regulations. These are discussed in the Commentary, which follows the five case studies.

A variety of communities—large and small, rural, urban and suburban—are portrayed. The screeners interviewed were chosen in part because they also vary—in the nature of their background and experience and in the way their positions are structured. Some are responsible only for the screening of three- and four-year-olds; some also are responsible for kindergarten screening.

The five case studies presented here reflect interviews with eight screeners. This approach allowed us to understand the full range of programs and also provided material for disguising the identity of screeners and their programs. A major concern of this project was protecting the anonymity of our sources so that they could freely communicate to us their concerns and disappointments as well as their achievements and rewards. Thus we are prevented from thanking our collaborators by name. As the reader will learn, the one common experience they all shared was a hectic schedule; therefore their efforts represented extraordinary generosity.

Because the first case presented is the most complex and complete—others highlight variations and special aspects—the reader is urged to begin at the beginning. However, for those who wish quickly to find a discussion of a particular topic or type of community, the following roadmap, combined with subheadings of the text listed in the Table of Contents, should provide an adequate guide.

We first present a vignette describing a typical screening session. The five case studies are presented next, beginning with "Sara Compton," an early childhood specialist who coordinates the screening program for three-and four-year-olds in a suburban town. The second case study is that of Nancy Garr, a kindergarten teacher who became a learning disabilities specialist. She is now in charge of screening programs for both kindergarten children and three- and four-year-olds in a small town. The third case study is that of Alice McNulty, who is employed in an industrial city with a large bilingual population. A speech and language therapist, she is a member of the team responsible for organizing and carrying out screening of three- and four-year-olds. The fourth case study is of a formal collaborative consisting of several towns. Harriet Kaye, a specialist in early childhood and special needs, is in charge of three- and four-year-old screening. Finally, Julie Konner, a speech and language therapist in a regional school district composed of several rural towns, coordinates both kindergarten and three- and four-year-old screening. Following the five case studies is a commentary in which special problems and issues are discussed. The Appendix provides a list of instruments, including addresses of publishers.

The anonymity of our sources would have been jeopardized by including in the text actual materials used in the screening programs, such as publicity releases and letters reporting results to parents. Readers interested in these materials may contact the Early Childhood Project for further information.

In order to clarify issues related to screening, educational evaluations and intervention programs are discussed briefly in the text. However, the reader is reminded that screening itself must not be confused with evaluation; it serves as a first step to identify children who may need assessment and intervention.*

We are deeply grateful for the tactful advice and consistent support of Carol Goodell, former Coordinator of Inservice Training, who conceived of the project with her usual combination of optimism and realism. Ann Taylor, now Director of the Early Childhood Project, has guided the manuscript through its final stages. Our greatest debt, of course, is to the anonymous screeners.

The three authors worked as a team to develop ideas and questions in preparation for the interviews. Stefi Rubin interviewed Sara Compton and wrote her case study. Tanya White interviewed all the other screeners and wrote the case study of Alice McNulty. She also provided the Appendix and took major responsibility for the content of the Commentary. Grace Baruch wrote the Screening Day Vignette and the case studies of Nancy Garr, Harriet Kaye, and Julie Konner. She also served as general editor.

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*A discussion of this issue and of other aspects of screening, including a review of instruments, can be found in "A Guide to Early Childhood Developmental Screening," by Samuel J. Meisels (1978). This document is the first in the Early Childhood Project's publication series.

SCREENING DAY: A VIGNETTE

The setting is a preschool classroom, converted for a day of screening. Several apparently enticing, and therefore distracting, objects are covered up; tables and chairs are separated into several "stations", and there are coffee, juice, and cookies for refreshments. Materials are prominently displayed on how parents can build various skills by working with their children at home. Parents seem pleased to get these to take home.

Several mothers and some younger siblings are seated around a low table. A staff person, who is also a mother whose child attends the school, acts as greeter, helper, and general trouble shooter. There is a low hum but calm atmosphere, punctuated by occasional shrieks from siblings. The children being screened at the various stations appear dressed up for the occasion. A little blond girl in a pink pants suit and eyelet blouse is smiling as she shows her ability to perform requested actions, such as stacking blocks in order of size. Her mother looks on somewhat anxiously from across the room.

The screening coordinator is testing a small boy. After he catches a ball she throws, she asks him to stand on one foot while she counts aloud. "I can't" he says, but he agrees to try and manages to balance for a count of ten. But when she says, "Fire is not, ice is . . .", there is silence, and when he is asked to make a red X on a piece of paper, he reaches for a green crayon. The coordinator marks scores on a sheet of paper that will travel with him. He goes off with a nurse for hearing and vision tests.

The children get name tags as they enter. One boy starts to cry as it is pinned on: "I don't want a name tag." He is reassured that he doesn't have to have one, but his mother looks embarrassed.

Children circulate to the various stations—working with the screening coordinator, talking with the speech and language specialist, accompanying the nurse for the hearing and vision tests.

An adjustment counselor talks individually with each mother. A mother is telling of her concerns about her three-year-old son. She had a difficult pregnancy, and recently had been hospitalized quite a bit. The boy stayed with her mother, who is in a walker, so the boy "can get away with a lot." He has been hospitalized himself with a serious viral illness and also was accidentally poisoned last year by swallowing pills. The mother feels that it is natural that he will show signs of these stressful experiences, but her husband "expects more of him than he can do." She feels that because he isn't home a lot, her husband doesn't understand the limited capacities children have.

The adjustment counselor tells the observer later that many mothers come because the husband doesn't think the child is doing well enough. She wishes more fathers would come to parent meetings, as they really need the information, but she can't get any funding to pay for evening meetings. And as is typical, the scene today, except for the children, is an all-female one — female staff, female parents.

A new parent arrives (appointments are scheduled at half-hour intervals) and announces that she has forgotten to bring the developmental history form she had filled out. A staff member gets her another one. Her son, Aaron, goes off with the nurse. They soon return, and nurse announces, "He did fine — uh, that kid sure has a lot of energy!"

The break that the coordinator has scheduled in case screening runs overtime has come, and since all has gone well, the staff members visibly relax. Very quickly, however, the break is over, a parent and child arrive for their appointment, and the staff go back to their stations.

SARA COMPTON

THE SCREENER AND HER COMMUNITY

Background

Prior to her current position as Early Childhood Specialist in the public school system of Bloomington, Sara Compton had extensive teaching experience with both handicapped and non-handicapped young children. For three years, she was a teacher and director of a nursery school. After moving to Massachusetts, she advanced from volunteering to substitute teaching to full-time employment for two years as a teacher in a private, self-contained program for multihandicapped toddlers and preschoolers. Sara's formal educational background included a B.S. in elementary and physical education and an M.S.Ed. in preschool special education. Her informal background included her own experiences as a parent.

Despite her substantive training and experience in early childhood special education, Sara had neither planned nor implemented a screening program prior to her current employment. In fact, her prior experience was limited to a course module on screening in graduate school and educational evaluations of children referred to her through the screening process. When interviewed, Sara had held her current position for a full school year and one summer.

Sara's current job description has several facets to it, only one of which specifies the screening of children ages three and four. Sara's primary responsibilty is as a teacher of children with special needs ages three through six; she teaches from 8:45 to 11:30 daily. From 11:30 to 3, she is expected to fulfill a host of other duties: parent involvement; coordination of services for her pupils (including their integration in regular preschool or kindergarten classrooms); development of relationships between special education and regular education as well as between preschool and kindergarten services, and outreach to agencies in the community, i.e., day care, Head Start, nursery schools, special education facilities, family service agencies, and mental health centers. Thus, Sara is a teacher, parent worker, community liaison, preschool specialist, and screening coordinator.

Given the scope of her job (which could easily entail more than the 8 a.m. to 3 p.m. specified in her contract), Sara receives some assistance from her classroom instructional aide and from faculty, staff, and administration. Sara's full-time aide is a certified regular educator who functions as a co-teacher in the classroom. Parent work, community liaison work and the facilitation of mainstreaming and of screening are other responsibilities Sara delegates to her.

Sara also works closely with the local education agency's (LEA) Special Education Youth Advisor, whom she meets with weekly. Overseeing the Special Education Youth Advisor is the Assistant Administrator of Special Education who reports to the Special Education Director. At the top of the hierarchy are the Assistant Superintendent and ultimately the Superintendent. The supportiveness of the special education administrative staff is especially enhanced by the proximity of their offices to Sara's classroom. Sara not only has had easy access to the administrators directly "above" her, but can also take advantage of the nearby photo copy machines and files. However, without a telephone in her own classroom, Sara has to "beg, borrow or steal" phones located only in the secretarial or staff offices. Given the amount of telephoning required by her varied duties, Sara finds that her preschool classroom has certain drawbacks in terms of facilities for coordinating screening and services.

Screening was the only aspect of Sara's original job description about which she had questions. She was uncertain about its scope and did not initially realize that she would end up organizing an entire screening program. She attributes her "naivete"about what screening required in part to her own lack of experience and training and in part to the LEA's lack of knowledge about screening. (The LEA itself had been found to be in noncompliance vis-a-vis preschool special needs services during a State Department of Education audit.) One week prior to beginning her job, Sara learned of the Summer Inservice Institute on screening conducted free of charge by the Early Childhood Project. Her request for release time to attend it was granted by her new employers. Thus their interest in having her bring their LEA into compliance was underscored from the start.

Sara found "the contact with other people in the follow-up sessions" the most valuable aspect of the screening Institute:

> People sent each other their screening materials. Since everyone had done some screening or had been on a screening committee by the time of the follow-up sessions, there was a lot of knowledge to share. It was helpful to find out what to expect and to see that there were various steps. When I later got inundated with calls in response to our publicity , I contacted people who had participated in the Institute with me for advice.

Sara also appreciated learning more about the Early Childhood Project and its important resources, the regional consultants.

The Community

Bloomington is a suburban community with a population under 30,000. Although generally perceived as a middle-income, commuter community, Sara reported, Bloomington also includes upper-income professionals, working-class people, and pockets of rural poverty. Predominantly white, there is minimal diversity ethnically and linguistically.

Sara estimates that three- and four-year-olds in Bloomington number less than 600, based on 1977-78 census data and on 1978 kindergarten registration figures. Within Bloomington, there are three nursery schools, one day care center, one Head Start program, one integrated preschool special needs program and Sara's own segregated preschool special needs classroom within the public school system. However, Sara estimates that less than 50 percent of the children entering kindergarten have had prior preschool experience.

Bloomington's noncompliance with state and federal special education legal mandates for services to three- and four-year-olds was a catalyst in creating the job which Sara subsequently performed.

> It's a new area for the public schools. They know what the state said in the audit report, but they didn't know what it all meant. The PL94-142 law in that area is wide open and new to them. They just didn't realize how diverse and big a job it is for this size of a community.

Sara believes that although her position , both as a teacher and as a screener, was intially designed to meet the short-term, administrative needs for compliance, its purpose has eventually expanded to include the immediate and long-term needs of young children and their families. Once compliance with the laws was achieved, the far-reaching implications of PL94-142 became more visible to the school system. Revitalizing the entire spectrum of early childhood special education services now seems to be a possibility, especially if federal funds can continue to be used. (The criteria for the use of federal funds in such programs are currently somewhat ambiguous.)

Like other communities struggling with serious school finance problems, Bloomington's attitude towards the costs of early childhood screening had been to set a priority on economy and expediency. Sara discovered that in the past, few preschoolers with special needs had been referred for evaluations, perhaps because public school placements for them were non-existent. One of Sara's first assignments was to conduct a three week, half-day, summer program called an "educational assessment classroom." She was given the names of kindergarteners who had scored low on the kindergarten screening and she traced preschoolers who had either received partial evaluations without any subsequent service or who had received evaluations, but who had been placed in non-public school settings. She then determined which ones would benefit from the summer program.

Sara realized that in her efforts to bring the school system into compliance, she would have to deal with several unstated assumptions: cut costs by transferring children in out-of-district placements back into the district; and identify preschoolers with special needs, but not more than a predetermined number needing a "substantially separate placement."

Sara also discovered that although the school system's kindergarten screening appeared to be in compliance with the law, the data it produced were often not used to refer children for evaluations. Children identified through the kindergarten screening had tended not to be referred because alternative placements for them within the district did not exist, while out-of-district placements were rarely utilized because of the expense. Instead, children of concern to screeners were simply placed in the regular kindergarten program without modifications, except in cases where children worked with Title I itinerant teachers in small groups. Occasionally, parents were advised to keep their child out of kindergarten for a year to "wait and see" if developmental delays remedied themselves. Although kindergarten screening occurred in the spring prior to school entry, referrals for evaluations, when made at all, were postponed until the fall. In such cases, kindergarteners typically then repeated kindergarten a second year until they were old enough for eligibility into resource rooms. Although kindergarten teachers were cooperative in identifying children's problems early, Sara noted that both they and parents were neither aware of their rights nor prepared to function as advocates who could challenge the school system's "wait and see"approach.

The school system's kindergarten screening procedures thus highlighted noncompliance issues which dovetailed with Sara's job description. Most dramatic was the limited use made of screening information because of the lack of available follow-up placements and related services. In the process, children's needs had been minimized. To be able to foster cooperation between herself and the kindergarten faculty, Sara needed to uncover how the system had operatd prior to her hiring.

Scheduled for a week in April by the kindergarten coordinator, kindergarten screening occurred in the town's two elementary schools. Letters were sent to all families with kindergarten-age children. An orientation meeting was held at both elementary schools to inform parents about the purpose of screening. Since kindergarten teachers as well as the learning specialist, nurse, physical educator and adjustment counselor in each school conducted the screening, kindergarten classes were covered by substitutes during that week.

The kindergarten screening consisted of a medical examination, vision and hearing tests, motor assessment, the Hainsworth Developmental History Questionnaire, the Caldwell Preschool Inventory, and a Draw-A-Person test. Screening scores were reported to parents, who were invited to meet with the adjustments counselor if there were any questions. Results of screening were also used to distribute children with low screening scores among the kindergarten classes so as to prevent any one teacher from having all those children in her class. Sara anticipated that coordination of the preschool and kindergarten screening would become necessary, especially given the kindergarten teachers' hope that Sara's program would not only serve as a preschool class, but also as a "transitional kindergarten."

SCREENING OF THREE- AND FOUR-YEAR-OLDS

Planning

In the summer when Sara began her job, she not only directed the educational assessment classroom cited earlier, but she also attended the Early Childhood Project's Institute on screening. Upon completion of the Institute, she conferred with the Special Education Youth Advisor about their next steps. New to the school system, Sara was reluctant to establish a screening program without first gaining input from those familiar with the system. She also did not want to alienate colleagues because of her new and possibly imposing title of Early Childhood Specialist. She and the Special Education Youth Advisor thus recognized the need to establish a Screening Committee in September.

In September, the composition of the Screening Committee was decided; appropriate persons agreed to serve on it—the instructional aide, the school nurse, the adjustment counselor, the Special Education Youth Advisor, a kindergarten teacher, the kindergarten coordinator, the director of physical education, an "itinerant" vision specialist, the speech therapist, a parent (recruited from a kindergarten parent group), and Sara. The Special Education Youth Advisor chaired the Committee's meetings while Sara functioned as co-leader, resource person, sub-committee monitor, and screening coordinator. The Committee met about once a month, usually after school, with attendance averaging around five members, relatively high for an "extracurricular," volunteer activity. The Committee's time line was designed to conform to the audit requirements. December was the target date for a draft of the screening plan to be submitted to the Special Education Director, February, the date for a final plan, and April, the date to begin screening.

Prior to the Committee's first meeting, each member was given a copy of the regulations about screening, a copy of the Bloomington audit and a copy of the Early Childhood Project's screening booklet. The Committee used its first meeting to explore a range of questions, such as: "Should preschool and kindergarten screening be conducted separately or together? What methods do we use to inform parents about screening? Which instruments should we use?" Although Sara had ideas about alternative models for conducting screening, she, too, had questions about the best way for Bloomington to proceed. Consequently, any member who did not live in Bloomington was given the assignment of collecting information about preschool screening from the town in which each resided;

> Their assignment was to go back to the community where they lived, contact their school department and find out who, how, and why they did screening for three- and four-year-olds.

It was anticipated that this process would not only personally involve each member, but also would yield important planning data. By November, the Committee had shared examples from their own hometowns and felt the need to commit themselves to specific instruments and procedures. They then formed three sub-committees—on publicity, instruments and logistics—which met independently and then re-convened in January to settle on a plan.

In formulating its screening recommendations, the Committee decided both to address the audit report and at the same time to generate ideas about what ideally should be done. Although Sara was aware of the fiscal implications of the Screening Committee's decisions about the scope and strategies of screening, she was not required to have a screening budget approved in advance. Estimates were made, however, of staffing costs, publicity, materials and supplies. Sara submitted expenses as they arose. The Screening Committee struggled to make choices that were philosophically consistent and educationally sound, rather than to make choices conforming to a particular budgetary ceiling. They decided not to second-guess administrative concerns about costs and instead aimed to develop an imaginative, responsive approach to screening. In the end, all of their recommendations were approved.

The Special Education Youth Advisor served as a communication link up and down the hierarchy. Sara credits the Special Education Youth Advisor with facilitating the development of their sophisticated screening proposals. Having had experience herself in early childhood, special education, and adjustment counseling, the advisor was "professional, bright, well-organized, and well-respected." She helped set high standards for the Screening Committee's plans and, because of her style and credibility, helped gain approval from the Special Education Director in the winter. The approved plan was then forwarded to the Regional Office of the State Department of Education where it was also approved as a sound response to their noncompliance concerns.

Outreach

In order to determine publicity methods, the Screening Committee first had to make a critical decision about the criteria for defining the population to be screened. In some communities that the Committee surveyed, the preschool screening literature (such as flyers, handbills, posters) restricted screening to an audience of parents who suspected their children had "substantial" needs warranting special education. By contrast, Sara and her committee advocated a preschool screening that would be open to *all* three- and four-year-olds in the community. The rationale for this position was as follows. First, the Massachusetts Chapter 766 Regulations called for screening of three- and four-year-olds in each community (although there has been leeway in how broadly or narrowly communities have interpreted this stipulation). Second, restriction of screening to preschoolers with "severe" or "substantial" special needs might eliminate children with moderate to mild disabilities. The Committee assumed that the medical profession would have already identified preschoolers with substantial special needs but may have overlooked children with less blatant needs. Thus, screening would reach out to a population that otherwise might be neglected until the mandatory kindergarten screening. Third, the Committee, influenced by Sara's perception of her own role, viewed its responsibilty to screen preschoolers as an opportunity not only to identify children needing evaluations, but also to provide parents with information about normal child growth and development. Screening was for all children, not just children with special needs.

As a result, the Bloomington screening literature was worded to avoid reference to special education. Instead, the literature told parents that screening would "let you know how your child is progressing and identify children who may need help before starting school." As Sara pointed out, no reference was made to how help would be provided, since that remained an unknown at the time. Given the historic gap between kindergarten screening and follow-up services in Bloomington, however, phrasing the preschool screening publicity materials in this way laid the groundwork for the provision of services in the future. In short, determining the scope of screening was not merely a technical decision; it was also a decision with political, fiscal, educational, and attitudinal implications.

Once the scope of the screening was approved (thanks in part to the Special Education Youth Advisor's arguments on its behalf), the Committee mapped out publicity strategies. Methods included radio announcements, newspaper articles, posters, handouts, mailings, and presentations. Specifically, Committee members made presentations and handed out brochures at meetings set up to prepare parents of kindergarteners for school. Posters were hung in churches, schools, and stores and a display was set up in the library. Handouts were made available for parents in those settings, as well as in day care and Head Start programs. A variety of letters were mailed: to parents of preschoolers identified by the census; to varied community agencies, and to "gatekeepers", such as pediatricians.

Preparing the written materials and media announcements was a task that several Committee members performed. Original materials were combined with adaptations of publicity formats used in other Massachusetts communities. The parent on the Committee was especially helpful as an "editor" who could identify educational jargon or phrases that might scare or offend other parents. Because the Committee had decided to hold preschool screenings monthly, materials also had to be worded in a way that was not tied to a particular calendar, location, or person; printed materials could then be re-usable and cost-effective.

Publicity materials were printed in February and March. Plans to schedule the first screening for April were abandoned because of insufficient lead time. Instead, two days in May and June were chosen. A time line was then planned to stagger publicity, with priority given to mailings to parents of three- and four-year olds. Letters included postcards to be returned by parents seeking further information. But plans for pre-made, mailing address labels fell through.

> It got down to a last minute thing. I and one other Committee member ended up writing all 300 labels, which proved to be a bit of a problem in terms of my other roles and responsibilities. I had to cancel parent conferences because the priority was in getting these letters out.

The Committee had estimated that six children per month, or twelve children in May and June, could be screened. To their surprise, 160 phone calls or postcards (a response rate of 57 percent) were received within the first month after the initial mailing and publicity! "The response was overwhelming. We had hoped for it, but we never envisioned that would happen, and then, what to do?" Sara and her instructional aide set up a system for contacting every respondent, primarily by telephone. Records were kept of respondents, phone interview data and next steps. Approximately 30 of the 160 respondents could not be reached during this period.

Phone interviews informed parents that screening was to "let them know how their child was doing." Sara also described the screening procedure to parents and asked them if they had any particular "questions" (purposely avoiding the term "problems") about their child. She explained that because of the volume of responses, priorities would need to be set. Sara recorded parents' comments and classified those who did or did not voice specific concerns. Since the Committee had not anticipated the need to prioritize respondents, Sara and her aide used their own judgment about who was or was not appropriate for the May or June screening. Those who did not have particular questions warranting immediate screening were told that they would be re-contacted for the fall screening and that they could call back before that if questions arose about their child.

Organization and Procedures

For the May screening, Sara selected seven children (one more than originally planned) and made appointments a half hour apart, with a break midway for the screeners; thus they were scheduled earlier even though it seemed unlikely that they had problems which would require referral. The other four children had potential problems (mostly speech and language) identified by their parents or pediatricians. One week prior to screening, letters describing the screening procedure and stating the appointment time, date and place were mailed along with the Hainsworth Questionnaires to the seven parents.

Included in the materials sent to parents whose children were scheduled for screening was also a physical examination questionnaire; either parents themselves or their child's physician were to complete the form. No one returned this form on the day of screening. However, since screening for preschoolers is itself voluntary, Sara acknowledged that she could not "push" for that information, and given the expense of hiring a physician, the school system could in no way afford to sponsor medical checks either. To compensate for this gap in information, Bloomington relied on the Hainsworth Questionnaire for clues about a child's need for a physical exam. Also, the school nurse routinely asked when a child last had such an exam.

One day before the screening, Sara confirmed most appointments by phone. For the May screening, two parents cancelled, one because of illness and one because of scheduling conflicts. Sara immediately contacted two more parents, who accepted last minute appointments.

One week prior to the official screening, the Screening Committee staged a practice session, which turned out to be an invaluable opportunity for testing out staffing, logistics, and procedures and for identifying areas needing modification.

The screening was held in Sara's preschool special needs classroom. Five discrete stations were set up. The first was akin to a welcoming and waiting area for parents and children; parents also reviewed their Hainsworth Questionnaire there. This area consisted of a child-size, round table with mostly child-size chairs, a shelf with books on childrearing and parenting resources, a display of newspaper articles about preschoolers, assorted puzzles, crayons and manipulative toys, and a place to hang coats. Cookies, juice and coffee were provided. Adjoining this area was a playroom with blocks and preschool supplies which functioned as a "reward" at the end of the screening for those children who wished to play. Third was the station at which the Denver Developmental Screening Test was administered and fourth was the speech and language area. The fifth station for vision and hearing screening could not be set up in the classroom because of acoustical problems. Options were less than optimal. An adjacent classroom was rejected because of its location and condition. A carpeted office was rejected because of its constantly ringing phone. Finally, the girl's bathroom across the hall was selected. Pictures were posted to make it a more cheerful environment, and, Sara reported, the children seemed less bothered by this setting than the adults.

Each station was staffed and set up for the following activities: First, the parent on the Screening Committee greeted parents and gave them permission forms to sign, as well as a Results Sheet that made automatic carbons which their child would take from station to station. Parents then conferred with the adjustment counselor about the Hainsworth Questionnaire they had completed in advance. Parents could accompany their child to the other stations, or children could separate and circulate among the remaining stations. The "Denver" station was staffed by Sara and the instructional aide, the speech and language station by the speech therapist, and the vision and hearing station by the itinerant vision specialist and the nurse. An observer-facilitator role was also performed by anyone on the Screening Committee who could attend the screening, monitor the process, and in general, assist so that screening went smoothly.

For the practice session, the parent on the Committee volunteered her kindergarten child and also recruited two of her neighbors' preschoolers. The screening was fully simulated, from sending these parents appointment schedules to reviewing results with them. Because of problems that surfaced during the practice screening, the Committee incorporated the following changes into their final plan:

a) Provide name tags for children, parents and screeners.
   On the child's tag, we put the child's name and birthday so that when he went through, we knew this child was three years and three months and we didn't have to do any calculations.

b) A parent, not the instructional aide, is the most appropriate greeter.

c) Provide space for children's and parents' belongings.

d) Eliminate or cover toys and materials that could distract children from the screening tasks.

e) Postpone reviewing of results until the child has completed the "circuit." During the practice session, parents often engaged each screener in a discussion of their child's performance at that station. This became a problem for individual screeners who felt pressured to explain their findings and possibly increase parental anxiety. The committee preferred that the adjustment counselor review the entire Results Sheet at the end of the screening to provide parents with a nonthreatening interpretation of the results.

f) Allow children to go from station to station in any order; sequence did not matter because each screener could tell by looking at the child's Results Sheet which station he or she had been at and which ones remained.

Instruments

Decisions about which instruments to use were made by the Screening Committee. The Committee examined several commercial screening instruments and developmental questionnaires. Four commercial measures were finally selected. First, the Hainsworth Developmental History Questionnaire for parents was chosen to check on a child's overall development. Along with a staff observation of the child, it was also a way to review a child's social development. Second, the choice of the Denver Developmental Screening Test was based more on the Committee's comfort with it than on its technical merits or deficiencies. Sara herself did not consider it the best instrument to choose, but agreed with the Committee because "in the first year of setting up a screening program, process is more important than the device." The Committee based their choice on practical factors, too. The Denver was "cheap, brief, and easy to administer and to change in another year without a lot of cost." It checked a child's vocabulary, gross and fine motor skills, and self-help skills. The Committee also selected the Symbol Screening Test by Good-Lite for vision screening because it was based on pictures, and, at the recommendation of the speech therapist, selected a tape recording, the Calibrated Tape Hearing Test, rather than an audiometer. Informal techniques were used to screen a child's speech and language skills, and information from other professionals such as pediatricians was included in screening results if parents brought in those reports or authorized the school to contact those professionals. In general, the screening instruments that were preferred were simple to score so that results could be immediately translated onto each child's Results Sheet. Also preference was given to commercial as opposed to "homemade" screening devices. Sara believed strongly that in the first year of screening, it was especially important to establish the credibility of the screening program. By utilizing standardized, reliable, commonly used instruments, the Committee had greater confidence in the screening results than if they had employed their own version. Parents could be informed that "according to this instrument, your child is in need of further evaluation," which would reduce the possibility that the instrument or the screener's competence would be challenged. As a result, the screening decisions would be legitimized and the screening program's reputation enhanced. Nevertheless, Sara acknowledged that the adoption of existing instruments or the creation of instruments with norms from Bloomington were possibilities for the year ahead.

Reporting Results

After each test was administered to the child, the screener at each station not only completed the score sheet for that particular test, but also immediately wrote the findings onto the child's Results Sheet. For example, Sara tallied the child's performance on the Denver before the child moved onto the next station. On the child's Results Sheet, she would check either "pass" or "re-check." Screeners also noted their reasons for a "re-check" score, for example, a suspicion that a child's cold affected performance. One "re-check" (the equivalent of a "fail") did not result in a child's referral for an evaluation. Two "re-checks" also did not necessarily result in a referral for an evaluation; rather, referral for an evaluation "depended on a pattern or on the specific reasons for the re-check." Screeners also indicated how long to wait (e.g., one month, six months) before scheduling the re-check.

Several other details about how results were recorded were note-worthy. An overlap between the Denver's language section and the speech and language therapist's section was identified in the practice session; to report results more clearly, Sara decided to write "Denver" next to her language scores to facilitate accurate interpretation. Results were cumulative, which enabled the next screener to note areas of concern or success indicated by the preceding screener. By the end of the screening, a complete profile was assembled and summarized on the Results Sheet. Because the Results Sheet was printed on paper sets that automatically created copies, the Screening Committee and each parent had a permanent copy for their records.

Sara had learned about the Results Sheet approach at the Early Childhood Project's Institute. There, a screening coordinator from a large, urban school system argued for its use. It had many advantages. Not only did it reduce paperwork, but it also provided parents with automatic feedback. Parents would end the screening process with knowledge about their child's development and would be able to leave knowing either that no further screening or evaluation was warranted or knowing why assessment was recommended.

As a child finished the screening, the adjustment counselor received the Results Sheet and reviewed the child's scores with the parent. The adjustment counselor explained "passes" in terms of the child's age-appropriate performance. To supplement the Results Sheet, she also gave each parent an annotated list of the screening tests that were conducted, and she invited parents to ask any questions. Upon returning home, therefore, parents had written material as a reference. They knew what each screening test consisted of, who conducted it, the results, and the specific areas for re-checking or evaluation. They also had been given a packet of booklets including: a booklet sponsored by the Mental Health Department which described regular and special education programs, camps, day care services, and parent groups; a booklet sponsored by the School Department; and a three-page list prepared by the Screening Committee, about home activities for preschoolers. The latter had practical suggestions for incidental learning such as "Encourage your child to walk along the curbstone" or "With your child, listen to sounds outside." This packet was an attempt to inform parents about child growth and development and to portray the school system positively, as a helpful resource.

For those children who received "re-check" scores, the next steps varied, depending on the "what and why" of the re-check. For example, children requiring vision and speech re-checks had re-screening written into their fall schedule: appointments were made with the nurse and speech therapist independently at the day per month allotted to the regular screening.

Sara was pleased with the screening day. Several children passed in all areas; a few warranted re-checks in vision or articulation; and one will likely be referred for a full evaluation. Problems that had arisen in the practice session had been ironed out and the screeners, parents, and children were at ease.

Future Plans

To cope with the high rate of response to their publicity, the Screening Committee is weighing several alternatives. One is to send respondents the Denver Parent Questionnaire, a simple pre-screening checklist, which would be returned and scored. Only children with scores falling below a cut-off would then be invited to attend the screening. The Committee may also explore the possibility of screening children directly in their day care of nursery school settings.

Whatever solution or combination of solutions that are selected, the Committee's priority of making screening available to all preschoolers will remain. Sara also intends to use the data on the high response rate as a way to justify the need for increased community outreach. She would like to see child development workshops provided in community centers.

Given the Committee's initial experiences with screening, certain logistical changes are planned for next year. Rather than all-day screenings, screening will only occur in the morning so as not to tax the energies of the preschoolers. And rather than screening only in the spring, screening will be routinely scheduled once a month during the school year. Personnel will be assigned to conduct screening on a monthly basis.

Screening procedures will remain relatively the same, although there is a need to reduce interactions between screeners and parents at each station. Sara remains concerned that such interactions only increase parental anxiety and she would prefer that the screening results instead be presented in a low-key manner at the conclusion of the screening by the adjustment counselor.

As to instruments used, no major changes are planned except for the addition of a Screening Evaluation Questionnaire, which will be pilot-tested in the fall. Parents will be asked to evaluate the screening day at the conclusion of their visit.

The reporting of this year's screening results to teachers will also generate a few changes in the coming year. In the past, kindergarten teachers were often "victims" of the school system's hidden message not to identify children needing special education or related services. Based on Sara's summer program, the educational assessment program, and referrals from kindergarten teachers, several children were identified who, without Sara's preschool special needs classroom, would have been placed in kindergarten even though that could have proved inappropriate placement. Next year

the school system will, for the first time, experiment with a kindergarten-first grade resource room to meet the needs of a population inappropriately served in the past. This positive step is due to data gathered during this year's screening.

Another issue Sara hopes the Screening Committee will resolve in the near future is the question of the confidentiality of screening results. These go into children's school files, despite the fact that the children are not yet of school age. Whether parental permission for screening needs explicitly to address the inclusion of screening scores in children's school records will soon be examined by the Committee.

Scheduling kindergarten screening for the spring is helping to build a new readiness on the part of the kindergarten teachers and administration to refer children with low screening scores for evaluations immediately, rather than postpone that step until the fall. In turn, kindergarten teachers, frustrated with screening that in the past has produced no guidance for them on how to modify their classrooms to meet children's special needs, will begin to re-consider their kindergarten curricula in order to meet those needs. And, meetings between kindergarten and day care staff are also more likely to occur.

Because data from screenings have had such an impact on special education services, Sara has become a staunch advocate of documentation. Compilation of statistics on screening outcomes, referrals, and educational plans will be used to determine where service gaps exist. Sara foresees that, as the conflict between thorough screening and limited services becomes public, the school system will need to recognize its obligation not only to screen, but also to provide services. Screening data will thus simultaneously serve as a needs assessment.

THE SCREENER'S ROLE: REWARDS AND PROBLEMS

Sara's responsibilities as screener were initially defined as one-eighth to one-fifth of her load. Having completed her first year as screener, Sara now believes screening will necessitate at least a quarter-time allocation. She is especially concerned about the amount of time that will need to be devoted to "in-house" relationship-building as well as to improving communication between the school and community resources. Because Sara is also a preschool special needs teacher, she is anxious that her non-traditional role be understood and respected by her colleagues. Sara's job is neither perceived nor officially defined as administrative, yet Sara has performed essentially administrative duties as part of her Early Childhood Specialist role. She has been expected to participate in meetings on program planning and grant-writing, for example, and to represent the needs of young children and their families; "My impact is greater than I had thought." Sara thus believes it important that she delineate her job responsibilities with her supervisors as well as carefully plan her time. She will also need to carve out a role for herself that enables her to continue working with parents and functioning as a community liaison, even though those responsibilities may be perceived as luxuries by the elementary school faculty.

Sara's need to "raise the consciousness" of her colleagues, not only about screening, but more generally about the special needs of all three and four-year-old children, has become apparent to her:

> People are really unaware of what three- and four-year-old children are like. You have to tell administrators, "You can't schedule these kids in the afternoon. They take naps!" Or, the vision person who might supect color blindness needs to be reminded that three-year-olds can't be expected to know about colors; that's a more advanced skill. There's a lot for everyone to learn about. There's anxiety just in terms of seeing these little tykes coming in and out of the school building. Even though they may have seen them as siblings of the elementary age children, it's now a whole new ball game.

Sara describes screening as a process constantly undergoing evaluation and adjustments. She anticipates that after each screening, questions may arise about an instrument or procedure which could result in changes for the following screening. Or, changes might be necessary because of shifts in administration, personnel, or Screening Committee membership. Thus a screening program is by no means fixed and is subject to periodic revision.

Sara is most enthusiastic about the interpersonal rewards of serving as a preschool screener. Especially gratifying is the opportunity to telephone over one hundred parents and talk with them about their observations and concerns. Sara enjoys the open-ended nature of these phone interviews. Discussing problems that parents voiced such as, "He just won't play with others" or "Gee, I don't really know how she's doing, she seems to know colors and shapes, but not too many letters" allowed her to reassure parents by providing them with information about normal child growth and development. Because most calls were made within ten days after Sara had received their postcard responses to the screening publicity, she was also pleased to surprise parents with a prompt call and positive image of the school system.

The decision to make screening available to all three- and four-year olds directly improved the school's relationships with parents. Well-written publicity materials elicited a high response rate from parents, many of whom "didn't think their child had any problems, but who wanted to see, since screening was available." Sara sees screening as an opportunity to reduce parental anxiety by "letting them know how their child is doing." She urges school systems to take seriously the issue of what kinds of messages their screening materials and procedures convey to parents.

Also rewarding to Sara has been her outreach work in the community — the opportunity to visit and talk with staff at local day care centers and nursery schools, who have tended to perceive the school system as unresponsive and closed. In the past, preschool teachers may have referred a child to the school system only to have the referral turned down or delayed. To alleviate this hostility, Sara has been informing teachers of a child's right to a full evaluation and of the teacher's responsibility for alerting parents not only to their rights, but also to their children's learning problems. Sara knows that negative attitudes towards the school system will change only if the information provided effectively answers teachers' and parents' questions. Sara predicts that "establishing a network is going to take time and rapport-building [but] openings are indeed beginning to appear."

NANCY GARR

THE SCREENER AND HER COMMUNITY

Nancy Garr describes herself as a *de facto* screening coordinator: "No one said, 'You're the screening coordinator', but there is no one else who does any of the screening work!" The town that Nancy works in is the town in which she grew up. After working abroad for a few years as an elementary school teacher, Nancy found herself, upon her return, accepting a job as kindergarten teacher in her home community:

> I went through all my schooling in this town, all my life. And then I thought I was going to get out of this dinky little town, and then I did, but I came back to it!

Her fondness for the small factory town is obvious. The population is mainly white and lower-middle class, with very few wealthy people, very few people on welfare, and very few non-English speaking families.

The building in which she works contains all the kindergarten classes—four classes of 25 to 30 children—and all the first grade classes. Last year her office was a doorless cubicle in the basement; this year she has been granted a first-floor room with a door.

As a kindergarten teacher, Nancy became increasingly preoccupied with children who were having learning problems, especially one easily distractible boy: "A fly would go by and he'd be distracted." She made a special effort to learn the eye exercises prescribed by his opthamologist and spent her free time working with him on these and on gross motor skills.

During this time Nancy was studying for her Master's degree. Her field was to be library science, but when she chose a learning disabilities course as an elective (in the back of her mind was the hope that it would help her with the distractible boy) she was "hooked". She changed to a concentration in learning disabilities. When she heard that a learning disabilities position was opening up in her school system, she applied for the job, which she got.

Her position soon grew to include resource-room teaching as well as traditional learning disabilities work for kindergarten through fourth grade children; at times her case load has been as high as 40. Because of her position, she found herself involved in the early attempts at screening that her town initiated. A team of three neighboring towns collaborated in these early efforts, which focused on kindergarteners:

> We all devised a screening device, and we went to each other's communities and we helped each other screen... It had a lot of bugs to be ironed out. This whole team of strangers would come, disrupt the entire school routine—there were parents and children lining the halls, screaming kids—we did not get very good results!

Learning from their mistakes, Nancy and one colleague did the following year's screening themselves, within their own school system only. This approach proved less disruptive, but Nancy was still dissatisfied with the instrument used, which she describes as a "homegrown" screening test with no established norms. During this past year she did research into available measures, sending for those that appeared useful and trying them out with children of her friends.

Although there was no official screening committee in her town, Nancy could easily consult with her colleagues because the special needs staff met weekly. She often used these meetings to make presentations on the advantages and disadvantages of the various meaures she was studying. Ironically, when she finally found the test she wanted to use, the Developmental Indicators for the Assessment of Learning (DIAL), which she learned about at the Summer Inservice Institute on screening, it was late summer, and she had no time to consult her colleagues. She was nevertheless able to order it for use, since her special needs director had indicated his willingness to go along with her choice.

SCREENING OF KINDERGARTEN CHILDREN

Organization and Procedures

The screening of kindergarteners has been a regular occurrence in Nancy's town for a few years. However, rather than continue to schedule it for the spring preceding the children's entrance into kindergarten, kindergarten teachers recently suggested changing to the fall, so that children would be acclimated to the school environment. This timing also fits Nancy's pet project, which is a series of informal small-group observations and teaching sessions with the new kindergarten children that gives her an understanding of their "learning styles" and gives the children a chance to get to know her: "We're really old friends by the time we screen!" This interaction with the children began when, as the learning disabilities teacher, Nancy invited other teachers to observe her methods of working with children on skill-building.

Given the value Nancy places on these "getting to know you" sessions, she is willing to accept the major disadvantage of fall screening—that it is too late to offer special help to a child over the summer or to suggest a placement other than regular kindergarten without disruption. The price paid in some cases, of course, is that an inappropriately placed child may end up repeating kindergarten.

To inform kindergarten parents about screening, an information meeting is held just before spring kindergarten registration. The turnout is discouraging to Nancy: "We only get maybe 25 percent of the population—just your most interested parents with the brightest children." At the meeting, the filmstrip that accompanies the DIAL for training purposes is shown to the parents so that they can see a child go through the screening process. Nancy and the speech therapist then explain the areas that are to be covered, defining "gross motor", "fine motor", and so on. In addition, parents are given a booklet that explains the whole process: "What screening is, why we do it, who does it, what we do with the results." The booklet is also given out at kindergarten registration. The cover is decorated with drawings by kindergarten children.

There is a certain degree of apathy among parents not only about screening, but also about the educational process and about their child's educational process. Perhaps because many parents are trapped in routine jobs and expect their children to be also, they do not exert a great deal of pressure for achievement. However, the town is growing rapidly, and Nancy expects that since the people moving in must have the money to build or buy homes, they may be more upwardly mobile and more oriented toward monitoring their children's education and achievement.

Instruments

Always a hectic procedure, the most recent kindergarten screening was even more so because the newly chosen test barely arrived before the first screening day, giving Nancy little time to refresh her skills and train her team. Even more pressure was generated by the dictum handed down by the administration that the screening had to be completed in a three-day period. The highest priority was not to disrupt school routine and to limit the need to hire substitutes for staff involved in screening. No classes were cancelled during screening days.

Nancy and two kindergarten teachers, using the DIAL, tested all the children in a class; Nancy herself tested any child suspected of having a problem. While a substitute took over a kindergarten class, the teacher escorted each child to Nancy's room for the half-hour screening and then took the child back to class. The speech and language therapist had a separate station in the room; because she disliked the language and speech portion of the DIAL, she used some indices of her own choice, including the Goldman-Fristoe measure of articulation and a series of pictures for eliciting speech samples. Nancy added to DIAL an index of auditory memory and a "coping item", a question such as, "What do you do when someone takes your toy?"

The hearing and vision component is done by the school nurse at any point during the year when the nurse can squeeze in time from her highly overloaded schedule. It has not been possible for her to do these tests before the screening days. Nancy is eager to find a way to solve this problem — she has even gone so far as to become certified in vision — but she is reluctant to intrude on what has been the nurse's "turf" unless invited to do so.

The parent component of the screening is done separately, at the time parents register their children for kindergarten — that is, the preceding spring. One disadvantage, of course, is that children and parents do not come in together. Although her staff has chosen to use the Hainsworth Developmental History Questionnaire, Nancy is concerned about its length and complexity. Parents "look at it and they shudder". After some negative parent reactions to being asked to fill out the forms themselves, Nancy or a colleague now sit down with each parent and go over the Hainsworth in a one-to-one interview. Even so, Nancy has noticed, many parents have trouble recalling developmental milestones — "I don't know when he walked" — and she worries that interviewers may be influencing the answers a bit by their probing. One advantage of the Hainsworth, of course, is the availability of standarized norms. On the basis of the norms, children who appear to have developmental problems are called in for early screening. Nancy was surprised that screening disclosed only "minimal" problems in these children, and she wonders whether "there are children out there with more severe problems that we are somehow missing."

The scoring of the Hainsworth, a major undertaking, was done by Nancy on her own time: sometimes her aide or her husband helped her. Nancy also found an occasional free hour when her classes were taken by her aide. She avoids cancelling her classes and case appointments at all costs, in order to maintain good relations with the classroom teachers who count on her.

Nancy has only two half hours of free time a week, plus an occasional free day when children are off on field trips, to catch up on duties — not only those connected with screening but budgets, educational plans, etc. Somehow Nancy also made time to go to the one nearby parochial school which has children from several neighboring towns, and screen the children from her town enrolled there. (To receive services, the parochial school children must be transported to her building by the parent; in some cases a child may be transferred to public school by the parents in order to have access to services.)

SCREENING OF THREE- AND FOUR—YEAR-OLDS

Outreach

Finding the three-and four-year-olds is the first step in the screening process. All the usual publicity means are used: posters in stores; radio and newspaper announcements; contact with preschools, and flyers sent home with school children. Yet only a very few parents requested screening until last year, when about ten came. In previous years, perhaps because of the wording of the notices, which referred to children with "substantial" disabilities, all the children who came in had obvious problems. This past year, for the first time, Nancy feels they were seeing "normal" children, probably because the publicity now uses the phrase, "If you have any questions about your child's development...". However, the message still is that screening is not meant for children with *no* suspected problems or concerns. The announcements do invite all parents of three- and four-year-olds to get in touch, "just to register, to let us know how many three- and four-year-olds there are out there." (Some who are brought in to be registered do sign up for screening.) Next year Nancy will be able to use census data to do mailings directly to parents, and she expects larger numbers to appear then.

Procedures and Instruments

The preschoolers are given individual appointments for a specific time on a specific day. For preschool screening, Nancy has chosen to use the Comprehensive Identification Process, but because the children who have come in so far are those with problems, most often language delay, there is a built-in barrier in testing them: "getting them to open their mouth."

Nancy has developed a novel approach partially to compensate for this; to get a language sample, she gives the parents tape recorders.

> One parent said, "Well, if you could just go with us for a ride in the car." I said, "Well, we just can't get the time to go for a ride, but *you* take the tape recorder in the car!"

Rather than use a standard questionnaire for the parent component, Nancy interviews each parent, asking questions about development that focus on the area the parent says caused her to bring the child in.

There is no automatic hearing and vision component for the three- and four-year-olds, although the team arranges for such testing if the parents request it, nor is there a medical examination, although children are sometimes referred for examination to a local medical center. Nancy was so concerned about one child whose parents appeared frightened to follow through on the suggested medical examination that she drove the child and parents to the appointment herself.

Of the ten preschool children screened in the most recent round, five were found to require some special help, typically in speech and language. Unfortunately, no services are available in the town at the preschool level (although there is a nearby federally funded program for more severely handicapped children), so the speech therapist and Nancy have been working informally with some of these children in the early morning before school starts.

Nancy plans to expand her outreach efforts for three- and four-year-olds by visiting the town pediatrician, who has only recently set up a local practice, and by being in touch more regularly with the local welfare office. She is in close contact with the local public health nurse and believes she learns practically at birth about children who appear potentially to have special needs. However, no services are available locally before children reach age three.

REPORTING RESULTS: KINDERGARTEN AND THREE- AND FOUR-YEAR-OLD SCREENING

For parents whose children showed no problems in screening, the team sends a letter with a "happy to report" tone. Parents of children with minor problems get a personal telephone call from Nancy; given the size of the town and her lifelong presence there, Nancy finds it easy to contact parents. When a child's problems appear serious, Nancy telephones to ask the parent to come in and go over the results with her. The call is followed by a letter. Copies of all correspondence with parents are kept on file.

Intervention Issues

Nancy finds the services available within her town painfully inadequate. There is no preschool program of any kind within the school system. As was described, she or the language therapist can only work informally with preschoolers (work that is not compensated for) or, if the problems are serious enough, they can recommend placement in the federally funded preschool in the next town. Older children who need speech and language therapy are scheduled for only twice-weekly sessions; Nancy feels daily ones are necessary. The special needs program is thus limited to her resource room plus speech and language therapy. Many children, for example, those with Down's Syndrome, are "tuitioned out" to a special program in the public school system of a neighboring town.

As usual, budget problems are the culprit. Even though many children had trouble functioning in large classes of 25 to 30 children in kindergarten and first grade, the only transitional class was just abolished. The teacher conveniently left, and the opportunity to save money was irresistible. Nancy feels that screening is perceived as a "necessary evil". It is fortunate that screening is mandated; everyone understands "if you gotta, you gotta." Nancy is convinced that a greater need for services exists, especially at the preschool level, than is yet apparent. Finding the children in need must precede convincing the town to provide for them, however.

Nancy is pleased that after much effort, a parent education class, sponsored by the school system, is finally starting. It will be a course in child development, mainly for parents of kindergarteners but open to parents of preschoolers and first graders. Each session will focus on a different aspect of child development—language, motor, etc. Nancy hopes that parents in the class, as they learn more about child development, will be more alert to children who need help. She expects the leader to focus on sharpening parents' observational skills: "This is what we expect a child to be able to do. Can your child do this? If he can't, come on and see us, talk to us." So the parent group is an important arm of her outreach effort.

Sending children away for help bothers Nancy a great deal. Her greatest desire is to run a preschool within her own school system: "I'd like to service children here... just take care of our own needs here."

THE SCREENER'S ROLE: REWARD AND PROBLEMS

Nancy's profound belief in early intervention, and thus in early screening, is a major source of reward for her work. Because she is good at organizing things, she would like to combine her screening duties with directing any new intervention programs. Nevertheless, she values her direct contact with children highly: "I would never want to lose the chance to work with children."

Her current need to juggle varying responsibilities, including a heavy case load, is due in part to the shortage of personnel caused by budget constraints: "You do put on a lot of hats, because there's no one else to put those hats on."

Looking at the situation from a positive viewpoint, she comments, "You probably get a little more experience in different areas that you normally would not have if you had a lot of people doing all different things."

Nancy found the Summer Inservice Institute on screening extremely helpful because of the variety of topics presented that were relevant to her different roles. "And," she says, "I gained a lot of insight into how other regions handle their problems." Of course, when her colleagues at the Institute learned about her methods of getting to know each child ahead of the screening time, their reaction could only be envy; they knew how impossible such a procedure would be in most of their own communities.

This unique opportunity clearly is just that to her—an opportunity and not a burden. So too is her heavy involvement in testing, scoring, and reporting results. To Nancy the advantage of thorough knowledge of the children greatly outweighs the disadvantage of her work load. She has no wish to involve people in screening who can't "match the child's name to a familiar face":

> It sounds like I'm power hungry. I'm not. But I have a better perspective on them and their needs and what can be done because I know who they are, I know them inside out by that time.

Nancy is aware that all this can happen only because the community is so small:

> You couldn't do this in a larger town. You couldn't get to know every child individually before you screen them. But with only 100 children... I know all their names, and if a name comes up for an evaluation when they're in first grade or second grade, I still know those children.

Nancy concludes, "I'm lucky. I'm really fortunate to have a job that I love. Not everybody I know can say that."

ALICE McNULTY
THE SCREENER AND HER COMMUNITY

Waterville is a large industrial city with many distinct ethnic neighborhoods. Because of court-ordered desegregation, children travel by bus around the city, which has several dozen public schools.

Alice McNulty has worked in the Waterville school system for many years. Orginally a teacher of drama, public speaking, and English at the junior high school level, she later earned her Master's degree in speech pathology and became a speech and language therapist at the elementary school level. Several years ago, while still employed in that position, she was appointed to a team organized to establish screening procedures for children ages 3 to 21 who were in need of special services but who were not already in a school program.

The combination of responsibility for speech and language programs and involvement in screening is not unusual, particularly in Waterville, where the whole speech and language department has historically played a large role in screening both for three-and four-year-olds and for kindergarteners. The Department was screening kindergarteners before Chapter 766 went into effect and thus already had a procedure worked out. When screening of young children was mandated by law, of course, a more comprehensive program was needed. Alice's supervisor, The Supervisor of Speech and Language, together with the Supervisor of Psychological Services, were in charge of setting up the new screening program. They appointed an organizational committee consisting of Alice, another speech therapist, a nurse, a psychologist, and an adjustment counselor. For several years now this committee has met regularly, adapting and reorganizing screening as needed. Indeed, the members themselves carry out much of the screening. Thus, this organizational committee also functions as a screening team. Gradually the team's responsibilities have come to focus entirely on three- and four-year olds.

Alice's work as a member of the screening team officially constitutes one-fifth of her job. Another fifth of her time is spent on assessments and on annual reviews of educational plans for preschoolers in the special needs, early childhood program within her school system. The remainder of her time is spent providing speech and language therapy to children in that program. Although the program staff includes a second speech therapist, a part-time graduate student assistant, and a part-time aide, it is Alice who has full responsibility for writing speech evaluation reports on all children in the program—currently about 70—and for writing educational plans for those who require speech therapy. The paperwork is unending: "I love my job, but I mind the paperwork. I dread some of it." Given such an overwhelming work load, she inevitably takes much of the dreaded paperwork home at night.

SCREENING OF THREE- AND FOUR-YEAR-OLDS

The first screening sessions for three- and four-year-olds were held in dismal rooms on the fourth floor of the school administration building, which Alice describes as "a terrible site." The only positive aspect of the setting was that the turmoil created by such poor facilities created awareness on the part of the school administration of the difficulties in carrying out screening under poor conditions:

> It was good for the school department to see how difficult it was to be a member of this team... upset parents with upset, disturbed children in a terrible environment for little kids! They were difficult days.

Currently, screening is held in several more appropriate settings in various parts of the city. During one week in the fall, four screening days are held in two classrooms in a new elementary school building; on the fifth day of that week, screening is scheduled for the auditorium of a public library branch. During the remaining weeks of the school year, screening takes place every Friday in a basement room of an older school in the center of the city. All locations provide a pleasant environment, in part because of the cordiality of the people there—principals, teachers, secretaries, librarians.

Outreach

A variety of methods is used to publicize the screening, with much attention given to the bilingual population. In early fall an advertisement in English, Spanish and Portugese is placed in newspapers and is sent to radio stations. The screening team stays in close touch with community agencies—the Department of Mental Health, early intervention programs, other human service agencies, hospital clinics, and private day-care centers, and nursery schools.

Announcements urge parents whose children "might have problems" in some area of development to contact the school department for a screening appointment, in order to help the children "make a more successful adjustment when they reach kindergarten."

Organization and Procedures

The person who answers calls and schedules appointments is a school department secretary who is bilingual. All those who call and receive appointments receive reminders in the mail, with maps showing the location of the screening.

About 200 children are screened in the course of a year. The first 50 referrals are scheduled for the fall "screening week". The remainder receive appointments for one of the weekly Friday screenings that occur throughout the year. Despite reminders and maps, "no-shows" are always a problem, usually running about one of every five appointments.

Alice is very concerned about the adequacy of outreach and about the logistics of scheduling and transporting city children. She finds it important to work "hand in glove" with day-care centers and other agencies and to build close relationships. This past year her screening team actually went to a large day-care center to screen children there. Other centers have arranged for minibuses to transport parents, children, and bilingual interpreters to screening sessions.

Still, the number of children screened seems inadequate to Alice:

> Although we're finding a lot of children, we must be missing more. There are those who are not involved with a human service agency, who don't read the paper, go to a clinic, or see the notice posted in the library.

A special effort is made to carry out all screening sessions in a non-threatening, welcoming atmosphere. Coffee and milk are served, and parents and children are never allowed to feel rushed. Because screening may be the parent's first contact with the Waterville school system, establishing a friendly relationship is a high priority for the staff.

Instruments

The week-long fall screening session is carried out by a large staff, permitting three children and their parents to be seen every half hour. Unless there is a separation problem, the child moves from station to station while the parent is being interviewed. Currently, parents are seen both by a nurse, who takes a medical history, and by an adjustment counselor, who obtains a developmental history. The developmental history consists of the Eliot-Pearson Screening Inventory and some "home-made" items. Because of overlap between the medical and developmental history, Alice hopes to combine these two procedures.

Each child is given the Comprehensive Indentification Process by a psychologist. A speech therapist then administers the Fluharty Preschool Language Screening Test (unless the child is non-English speaking) and obtains a language sample by playing with the child or by showing pictures to stimulate story telling. The psychologist and speech therapist each are able to observe the children while they are being tested by the other, an arrangement that Alice finds valuable. Finally, vision is tested using the Michigan Preschool Test, and hearing assessment is done by pure tone audiometry.

During the Friday screening days scheduled throughout the school year, the pattern is similar but less hectic. Each child is schduled for 45 minutes and no more than six children are seen on any one day. Because of the smaller scale of these sessions, it is not possible to test hearing; any child suspected of having a hearing problem is given an appointment for a full audiometric examination at a local hearing clinic. About half of the children seen during these sessions are sent to this facility, which is extremely cooperative and promptly returns written reports The screening team is currently reconsidering the problem of vision screening because they do not find the Michigan Preschool effective with such young children. A consulting pediatrician is working with the team to find new techniques.

Bilingual Screening

Those non-English speaking families who have been in contact with agencies or day-care centers usually arrive with a human-service agency bilingual social worker previously assigned to them. A bilingual speech pathologist administers a Spanish translation of the Fluharty. All others are aided by two Spanish-speaking secretaries from the school system, who sit with the parent during the medical and developemntal history-taking. The two secretaries are important, integral team members; they thoroughly enjoy participating.

Spanish-speaking children are tested by a Spanish-speaking psychologist. Occasionally, for speech screening the Carrow Screening Test for Auditory Comprehension is used. However, because it was standarized on Chicano children, while Waterville's Spanish-speaking population is primarily Puerto Rican, Alice does not consider the Carrow to be ideal. Unfortunately, it is the only measure available. The team tries to supplement the scores:

> If the child has been in some program—day care, nursery school, or early intervention—we get in touch with that program and ask about his connective speech to see what's really going on.

A position is currently open in the Waterville school system for a bilingual speech and language therapist, and the person appointed to that position will become an important member of the screening team. However, Alice reports that the position has been difficult to fill; few candidates have applied.

Reporting Results

After child and parent have completed the screening procedures, parents receive immediate feedback. While the child is entertained by a staff member, those who have worked with the pair sit down with the parent to discuss the results. Thus a dialogue is possible; the psychologist or other team members can ask further questions to obtain clarification; the parent can ask for explanations. Alice describes this conversation as "the best part of the whole process." She particularly values the rapport established since many parents come in with hostile feelings toward educational institutions because of their own childhood experiences. Moreover, many parents are there because a social worker or teacher was concerned about the child and initiated the screening appointment. Immediate feedback in an informal setting often relieves tension, allowing parents to go home knowing exactly what was found and what the next step will be. (Whenever any further evaluation is scheduled, parents are asked to have the child examined by a physician or clinic and are given a medical form to be filled out there.)

Although parents do not receive any written follow-up reports, a cover sheet containing scores and recommendations is attached to the screening packet and kept on file. Alice is not satisfied with this procedure, however, and hopes to improve it: "The information we're getting should be put together in some fashion that's readable so we could send it on to another agency."

INTERVENTION ISSUES

In part because screening is aimed at children already suspected of having some problem, a large number of children with special needs are identified during the sessions. The majority of these need and receive full evaluations. Another group requires only assessments of speech and language. For some children, the decision is to wait and follow them over a period of time, to see whether mild difficulties appear to be improving. Alice is concerned about the last group; ironically, they require a "shocking" amount of staff time, because of problems involved in getting them to come back for a second—or third—visit. Some of these children are already in a preschool program. Alice would like to arrange for the preschool to receive information about screening results, and suggestions for helping the child, immediately after the screening session.

Children who require only speech therapy are assigned for assessment and treatment by the Supervisor of Speech and Language, either to the speech therapist at their nearest elementary school, or, if that therapist's schedule is full, to a therapist who has time available. Although treatment is thus assured, it may involve traveling that is difficult for the family.

For children who need more intensive special services, the school system has an early childhood program that has space for about 70 children. The program has four classrooms, each with morning and afternoon sessions. Children are divided according to level of functioning, from severely delayed to those considered to need only "readiness" orientation. There is also a program for six to eight-year-olds who are not yet ready for kindergarten.

There are some conflicts with the administration over the nature of the programs:

> The school department doesn't like to provide services that aren't obviously educational.... They want to see workbooks around.... It's hard for them to [accept] the swimming program for these kids. You know, transportation and pool.... and these things are very important at the level we're at.... If we write occupational therapy or physical therapy into another educational plan I think [the administrator] will shoot the whole roomful of us.

Another problem is that the program is housed in a building rented from a church that is entirely separate from any of the other elementary schools. Alice finds this "segregation" a serious handicap, in part because children in the program have very few good language models. If the program were housed in a building with regular classes, interaction with other children would automatically provide such models. Moreover, because of the location, some parents don't realize that the program is provided by the public school system. As a result, Alice feels, the system is missing out on some good public relations.

THE SCREENER'S ROLE: REWARDS AND PROBLEMS

Currently there is no early childhood person at the higher administrative levels of the Waterville system. Alice hopes that there will be one soon, in part because she expects that this change will provide support and relief for an overworked staff.

The major benefit of last summer's Institute, Alice notes, was her enjoyment in meeting others engaged in the same processes as herself. She especially appreciated this because, as is true for other screeners, her busy schedule makes it difficult for her to devote time to building collegial relationships outside of her own screening team and early childhood program. She particularly craves further contact with people from other urban areas who are struggling with problems salient to hers such as, "Who pays for medical examinations of three- and four-year-olds?"

Asked about the rewards of her job, Alice responds:

> I love my job. I look forward to it every day. The greatest pleasure is from the parents, when they see that people really care about what's going to happen, when they come angrily with their advocates [and then] see that they didn't need to bring them.

HARRIET KAYE

THE SCREENER AND HER COMMUNITY

Harriet Kaye is Early Childhood Coordinator for The Highland Collaborative, a formal organization consisting of six small towns in the south-western part of the state.

From her high school days on, Harriet has been involved in work with children with special needs. In college, where she majored in special education, she became particularly interested in "the diagnostic aspect of identifying children and, after they were identified, trying to figure out where the child was.... That was the part I was intrigued by." Because she had had so much experience with children with special needs, the student teaching requirement was waived for Harriet and she worked in a hospital diagnostic center instead as part of a team that developed an assessment instrument.

After college, Harriet spent several years in classroom teaching. During this time she was often asked to do evaluations of children about whom other teachers felt concerned. When she came to the Boston area, she was hired to develop a special program for severely handicapped children. After two years spent designing and implementing that program, she obtained a leave of absence in order to attend graduate school and enrolled in a master's program that combined early childhood and special needs. While in graduate school, she participated in research about screening and assessment instruments. Shortly after completing graduate work and returning to her previous job, the position she now holds became available and was offered to her. She was known to the collaborative because of her work on a committee that visited a variety of local communities to review special education programs. The new position appealed to her because, "I'd been pretty much confined to one classroom up until then and I really felt I wanted to broaden my responsibilities."

In her new position as Early Childhood Coordinator, Harriet reports to a Director, who works with an "operating committee", made up of the Special Needs Directors from each town, and with a Board of Directors, which includes the Superintendent (or Superintendent's representative) from each town's school system . The towns vary in socioeconomic level but are mostly blue-collar communities with very few non-English-speaking families; they are large enough so that each has several elementary schools and a high school. Harriet is fortunate in the physical space available for her programs and her screening—a pleasant building with large, carpeted rooms and a playground built by parents and helpers from the larger community.

Harriet is responsible for screening all the three- and four-year-olds, and she is also the coordinator of all early childhood programs and services. Each town does its own kindergarten screening. She has a liaison person in each community, usually the school adjustment counselor, who assists with publicizing and carrying out the screening. Harriet heads a staff of about a dozen people—teachers, therapists, aides. Her responsibilities include doing the relevant budgets and scheduling classrooms and personnel. She designs and sets up the screening sessions and the preliminary publicity, and she is the person parents call for a screening appointment. In addition, a town may request that Harriet and her team rescreen kindergarten children for whom results obtained in the town's screening are unclear. And for those three- and four-year-olds identified as needing evaluations, a town also may request that her team do the actual assessments.

Athough her position is officially that of "teacher-coordinator", the time available to spend in the classroom in scarce and intermittent. There are five early childhood special needs programs sponsored by the collaborative, all located in one school building. Harriet has put much energy into integrating these programs into the school as a whole. She invites sixth graders into the classes to work with the children and has put together a slide show about the programs that she shows to teachers in the building. The show is also shown to school committes in the six towns and to relevant organizations in touch with children who will enter the school system.

With such heavy and varied responsibilities, Harriet is glad that she was able to negotiate an 11-month contract. She insisted on this at the time she was hired mainly to assure that services for children would continue during summers:

> If they're gone for the summer you just wipe out so much of what we've done for the year. So we start a five-week summer school in July. It's not for all the children... we just aim at the really low functioning children who need the intensive work over the summer.

Budgeting is somewhat complex because of the collaborative structure. Harriet assesses staff needs, equipment and supplies, transportation, and other expenses. Then, based upon the number of children she expects to serve, she arrives at a cost-per-child figure. For each child that a town sends to her programs it pays that cost as tuition; thus for any child identified as needing special services, a town cay buy a slot in the collaborative's programs. The town may also choose to provide its own services to that child. Under this system, therefore, a town pays for the program in proportion to utilization. (Currently, this reimbursement system is under review by the participating school systems.)

SCREENING OF THREE- AND FOUR-YEAR-OLDS

Outreach

During the big publicity campaigns held twice a year, Harriet drafts notices and supervises the radio and newspaper announcements. She turns the notices over to her liaison person in each community who then produces the copies and arranges for local publicity. Harriet herself has visited all the local nursery schools to describe the screening program and other services. She also contacts pediatricians and health clinics, but Harriet finds that:

> pediatricians are not our best referral. They tend to say, "He'll grow out of it", when the child, I think, could really use some support services and could benefit from intervention. So pediatricians need a lot of work.

More outreach is needed in general, Harriet believes:

> My ultimate goal is to identify all the people who are involved in early childhood—Headstart, early intervention, private day care, private nursery schools, pediatricians, visiting nurse associations—and just get the communication going... like providing workshops or conferences. That's our project for next year.

Notices about screening are phrased in as non-threatening a way as possible to indicate that screening is for children about whom there is some concern. The kinds of phrases Harriet uses are, "If you feel your child isn't speaking as well as he should, or may have a problem, or you would like us to look at your child, please call this number."

Harriet does accept children for screening whose parents call and say they have no special concerns but are curious about how their child is doing. She points out that since only eight or ten of every thirty children screened have any problem, her team clearly is seeing many children whose development is in fact age-appropriate.

Organization and Procedures

Although publicity announcements list one screening day, one day is not enough. On the announced day, Harriet is able to cancel the special programs in order to free staff and have sufficient classroom space, but she is reluctant to do this more than once. For the second screening day, therefore, she combines programs in order to keep them open yet release staff and space. About nine or ten children are screened per day; each is given a half-hour appointment.

> If a child comes in at 9 a.m., we greet the parent—hopefully the child will separate and be able to go to the three stations. I'll spend a half-hour with the mother. The child is usually finished by then. If not, I'll offer her coffee and sit her on the side and greet the 9:30 mother and start that. I may have to break away from her and wrap up the 9:00 child and then go back.

A free half hour is scheduled after every four or five children so that the staff can discuss each child while memories are fresh.

Each "station" is in a separate room—speech and language, concept development, motor development, hearing and vision. An aide takes the child around while Harriet does the parent interview.

The staff has found that in order to interest and reassure children, it is best for the first station to be gross motor skills, which include "fun" things like bean bags and jumping. Even children who have difficulty separating often get "weaned" in this way, although there are always a few that simply can't be tested. Such children are usually scheduled for a second visit. However, if there are other signs of trouble, or if the second visit is unsuccessful, they may be offered an eight-week placement in one of the classrooms for diagnostic purposes.

Children are given appointments for screening only if a parent calls in directly. If a nursery teacher is concerned about the child, the teacher must get the parent to call. In that way no one is going behind a parent's back, Harriet feels.

Parents who call because a teacher has expressed her concern to them usually are quite anxious about the child. Those parents who have already had some concerns themselves, however, are often reassured when they learn help is available:

> A lot of them heard about it from a friend of a friend or somebody's bus driver across the street... They didn't know there was help available before kindergarten and are really anxious to get [the child] into the program.

Instruments

Like so many of her colleagues, Harriet is less than pleased with the instruments available to her. Despite her strong background in this area, Harriet restudied the issue of measures when she assumed her current position. She reread her notes from the Summer Inservice Institute and decided on the Developmental Indicators for the Assessment of Learning (DIAL), since the format matched the staff available to her; each staff person could administer the area of her specialty. The DIAL lacked a social-behavioral component, however, so pieces of other measures had to be adapted for that purpose. Some indices of sensory-motor integration were also added by the occupational therapist.

No medical examination is included during screening; Harriet has found no way to require, or to provide one. (Of course, for any child who enters a program, a physician's examination and immunization record are required.) The hearing and vision component is done by the school nurse, who has the usual problems with finding or adapting measures that work with very young children. For vision, increasingly smaller pictures of familiar objects—apples, ice cream cones, hamburgers—are used. For hearing, however, the staff finds they must rely a great deal on the histories given by parents, who are questioned about behaviors that may indicate a problem—sitting very near the TV, a history of ear infections, and so on.

The major problem Harriet finds, is that test scores alone do not adequately reflect children's deficiencies, or skills, in the various facets of areas tested, especially speech and language. The teacher's or therapist's observations and impressions are therefore crucial.

Reporting Results

As the child goes from station to station, a Results Form also circulates that is premarked with the normal cutoff points based on the child's age. Each staff person then can indicate the child's actual score and can see at a glance any clear-cut problem areas. Each staff member also tries to write a brief comment on this form at the time of testing, e.g., *refused to try, tried and failed, did fine.* With this information, Harriet can provide some feedback immediately to the parent who is told that if there are any concerns, the staff will be in contact by telephone within a few days.

Harriet feels that giving immediate feedback is important:

> They're always anxious, and they want to know: what did he do?... I try and give her an idea. I let her look at what the child did... I think it makes them more anxious if you hide it or say, "We'll let you know later"... because they want to know then.... They're going to go home and Dad's going to want to know how he did and what happened.

Each family also gets a follow-up telephone call and a written report that explains "exactly what the child was able to do, what he was not able to do, what his behavior was like, if we'd like to see him again, or if we think further testing might be in order."

The letter states the reason for referral—who made the referral and why—followed by a narrative about how the child behaved during testing (cooperative, distracted, etc.). Results for each category, with specific task descriptions, are then reported, either as appropriate to age level or as mildly or moderately delayed. If further testing is recommened, the letter so states.

INTERVENTION ISSUES

The screening team is free to recommend an evaluation without consulting the town the child comes from. The town may decide to take responsibility for doing the evaluation or may ask Harriet's team to do it. Evaluation usually proceeds smoothly: "Testing is no problem... that's the whole purpose of screening, to identify children who need to be looked at more closely."

Services, of course, are a more complex matter. Each town decides whether results of testing indicate that skills are delayed enough to require remediation:

> That's not my decision... if they decide that he is delayed enough and they want him in the program, then if they pay for it and if there's room, I'll take him.

The problem of whether there is room is also complicated. The five programs Harriet coordinates are divided by the nature and degree of developmental delay, and openings do not always match current needs. During the first fall screening Harriet coordinated, children were identified for whom there was no appropriate space. Harriet was able to convince the operating committee to start a new class and hire a new teacher. But her plans to schedule another screening for that winter were overruled; the committee was fearful about finding more children in need of services when the new

class was already filled and there was no money for additional classes. So the next screening was scheduled for spring, with any resulting placements to be for the following September, when space would open up. Harriet is now concerned that spring screening may turn up more children needing September placement than there are places. She has already had to fight hard to keep classes to a reasonable size. From the perspective of the town's budget, the cheapest solution is to squeeze more children into each class or move some children from a full-day program to a half-day. And in order to hire another teacher, tuition money must be available from more than just a few children. Thus there are often conflicts about what to do when additional children are identified. Harriet has so far successfully refused to keep adding children to an already full classroom.

In dealing with conflicts between budgets and needs, Harriet has struggled to clarify her role, both for herself and for those she deals with. She defines herself as an employee of the collaborative, "not on the town's side or on the parent's side," although, "I try to be an advocate for parents for services and let them know what their rights are." She gives her opinion on what the needs are, but is careful not to interfere between parent and town nor to play one off against the other. She accepts the fact that the decision about services belongs to each town and to the parents.

Fortunately, not all children requiring remediation need to enroll in the special classes. For slight delays in just one area, the screening team has developed suggested activities for parents to carry out at home. If the child attends nursery school, copies of the suggestions are also provided to the staff there.

Parents of children with behavior problems are referred to parent groups run by school adjustment counselors or social workers in several of the towns.

Educational plans may be written by the collaborative's evaluation team or by the town. For children who appear to be candidates for one of the five special programs, the town often requests that the screening team do the evaluation. In such cases the team does the testing and sets the educational objectives.

THE SCREENER'S ROLE: REWARDS AND PROBLEMS

None of the complex situations Harriet must deal with have interfered with her satisfaction with her new position:

> The rewards have mostly been in expanded opportunities and more responsibility, more of a challenge... I'm very involved in regional programs, and I've spoken at workshops... I've gone to other areas and learned a lot... met a lot of people who are involved with those other programs, finding out what they're doing, sharing information.

Harriet has also found that she enjoys being an administrator at the particular level she occupies:

> At the level I'm at now, I'm involved enough and have enough control over my programs so that I can give it the direction I want... hire the staff I want and the other tutors I want and provide what I think is a high-quality program. But I am not so involved in administration that I have lost contact with the children.

Harriet is sensitive to the tensions that can be created when a new person assumes a position, as she did this past year.

> You hate to go in as a new person and just start changing, you know, because it tends to make everybody who has been there a few years real anxious. So I tried just to coast in the first year, and now I'm trying a little bit tighter controls... I didn't want to come and just change, change, change, but I've just cleaned up and organized a lot and I have the program running a lot more smoothly, I think. Now I'll really start making program changes.

Harriet found the Institute on screening helpful in her new position. Although some material presented there was already familiar to her because of her strong early childhood and special needs background, she benefitted from intense study of various screening instruments and from:

> a lot of talking with the other people who are doing it—you know, how you organize your screening, how do you work with this problem—just the contact with the other people was probably the best reward from the workshop.

Among Harriet's most important future plans is a project to adapt, for parents of three and four-year-olds, manuals written by a colleague for kindergarten parents on how parents can work at home with their children to promote optimal development. With another colleague she has applied for funding to support this project. Even if there is no funding however, she is determined to carry it out.

For many children, Harriet feels, the most powerful intervention is that which takes place in the classroom:

> I don't see the value of pulling a lot of three-year-olds out for one-to-one language therapy and then dumping them back in the classroom, having no carryover. I'd rather have our speech person spend her time in the classroom with the child—it is a more natural setting for intervention. There's so much in the classroom that the teacher is already doing. If the therapist can go in and work with the teacher and work with the child, I'd really rather see it set up that way.

Educating parents and teachers about such an approach is a major project for the near future.

JULIE KONNER
THE SCREENER AND HER COMMUNITY

"Winters are harsh, summers are beautiful, and everyone knows everyone else." The newly adopted community Julie Konner describes in this way is a big change from the suburb she grew up in. Determined to remain in the part of the state where she had attended college, Julie was happy to obtain a position as speech and language therapist in the Bristol-Glenwood Regional School District, which is actually a group of six towns, all relatively rural and isolated, near the New Hampshire border. The socioeconomic level of the communities is varied—a heavy representation of working-class families, a few rich gentry, and few farmers. Ethnic diversity is minimal.

Each town has its own elementary school that goes from kindergarten through fifth grade. All children then go to a regional school serving all the communities.

As Julie describes the recent changes in her responsibilities:

> I became involved in kindergarten screening through volunteering my efforts just to be part of it. What happened was that eventually, through a series of steps, I became in charge of it.

Her involvement in screening grew when the kindergarten staff who had run the screening found themselves enmeshed in disagreements with the administration. Julie was seen as a mediator who could take charge of the process without offending either side.

Kindergarten teachers had developed their own measures and methods for checking their students after school started in the fall. Screening of three- and four-year-olds at that time was limited, both by intent and by wording of publicity, to children already suspected of having special needs: "What they did was send out a flyer that said, if you think the child has special needs, sign up and we'll take a look."

The summer after serving as coordinator of kindergarten screening, Julie decided to enroll in the Summer Inservice Institute on screening so as to learn about screening of three- and four-year-olds. The ideas and material she brought back to relevant school personnel in her district resulted in her becoming coordinator of three- and four-year-old screening.

Julie does not consider herself to be an early childhood specialist, although she has taken some child development courses as part of her degree. Other important components of her background were her actual experience working with young children as a speech and language therapist and, a major aid in her current position, the Institute on screening.

As for so many other persons in charge of screening, that role is only one of several. She and one other colleague have the responsibility for direct speech and language services in all the district elementary schools. The number of schools with children who need her services varies from year to year but usually she must visit at least three schools. In a rural district this means a great deal of travel. Julie also works with the children in the school system's special needs preschool that serves all of the towns. There are presently eight children in this nursery; their ages range from three to seven.

During the spring months when screening takes place, Julie spends about 35 to 40 per cent of her time on screening-related tasks. To get done what she feels needs to be done, she often has to work late afternoons, evenings and weekends. She has reports to do on her speech and language cases, and because of her concern with screening, she is compiling a handbook of materials—samples of letters sent out to parents, narratives of procedures used and so on. Sometimes there are conflicts between her role in screening and her work as a speech and language therapist. On days when a screening session is held, she is forced to cancel other appointments. Sometimes important phone calls interfere with her case load, currently about thirty children spread among three schools. Some relief may be forthcoming:

> Next year there's a possibility that my caseload will be reduced so that I can spend more time [on screening]. I may be able to set aside a day a week for planning, so that will be nice.

Julie reports to two people, the Special Needs Director and also the Principal of the consolidated district elementary school. (As a screener she reports mainly to the Special Needs Director; as a speech and language therapist she reports to both.) Fortunately, she finds them supportive and has good relationships with both, thus avoiding the vulnerability to conflict such a structure might bring.

SCREENING OF KINDERGARTEN CHILDREN

There are about 150 kindergarten children in the six elementary schools. When Julie became the person in charge, much of the screening program was already in place. As new coordinator, Julie promised the teachers that for two years they could use the measures they had developed. They use a "station to station" model with four stations set up in a large room such as the school gynmasium, and a separate room for hearing and vision tests. The screening team goes from school to school. The team consists of Julie and the other speech and language teacher, and a nurse. Julie has found the school nurses, who do the hearing and vision tests, to be important team members, especially in dealing with parents of three- and four-year-olds, who are not yet in contact with the school system.

> Our nurses are actually our link to the community. They are our social workers, so to speak... they know what's happening. The parents trust a nurse, and they'll tell the nurse things that they won't tell the teacher, because they're not threatening... The nurse can go in the home.... it's relaxed and it's just different. They're really a valuable resource in terms of a link with the parent.

A staff person escorts each child around as each station is checked off. Physical examinations are done by the school physician, who comes in for this purpose before the screening dates (mid-November) so that results will be available for each child as screening starts.

The kindergarten screening does not have a "parent component"; parents do not come in nor do they fill out any special forms, although the information given by parents at kindergarten registration is available. Julie would like to add such a component as soon as possible.

Several aspects of the kindergarten screening concern Julie. First, the teacher-developed instruments have no norms. When each child is discussed at the end of the screening day, the team assesses mainly whether the child has shown grossly inadequate performance in any area. Not having a standardized instrument makes it difficult to interpret or evaluate the errors a child makes. For this reasons, Julie would strongly prefer using a standardized instrument such as the Gesell.

Another major issue is the timing of the kindergarten screening, which has traditionally been done in the fall so that the teachers have had a chance to get to know the children. In contrast to the teachers' preference, Julie would like screening to be done the preceding spring. The knowledge gained, she feels, would be very helpful in planning the fall curriculum.

In past years there have also been problems in making decisions about the children screened. There were some who clearly needed evaluations, and those recommendations were easily made. But for too many other children, "We sat on a fence; we just didn't know what to do about them. Should we leave them alone? Should we do a consultation?" Typically, the decision was made to recheck them in January:

> So I run around with my list in January... "Well, how's this child doing?" "Oh, the child's doing OK." Then come April, we're getting referrals, because it's the end of the year and they don't want to put the child in first grade, but they don't want to keep him back in kindergarten.

The difficulty, Julie feels, was in allowing uncertainties to result in a recheck recommendation. Next time, she vows, "If there's an ounce of doubt, a shred of doubt, the child will receive an evaluation."

Through such evaluations, Julie hopes, the needs of the child can be met, and recommendations implemented, by individualizing curriculum within the classroom: "I think a lot of the problems aren't necessarily special problems, but are remediable through the classroom." Julie is eager to convince teachers to accept and implement this approach. Teachers too often are reluctant to refer a child for screening out of fear the child will be labelled in a negative way and removed from the regular classroom. Knowing they themselves can provide help by modifying their curriculum should alleviate these fears.

SCREENING OF THREE- AND FOUR-YEAR-OLDS

Julie had much more planning to do, and could be more innovative, in the screening of three- and fou-year-olds.

> I was able to pick whomever I wanted to work on the staff, which was nice, because I picked people I knew would work out... people that I also knew had a feel for this.

Her core team consisted of herself and the other speech therapist; one of the regular kindergarten teachers; the teacher from the special needs nursery program, and a special needs teacher who works with older children. This team did the planning; a larger group was recruited to do the actual screening.

Julie was very pleased with her core team; she knew that when she described what needed doing to them:

> They would do a lot of the work and I wouldn't have to worry about the quality of it... it would be top-notch. It was great. It was really a good team effort, I think. I was delighted. I don't think we realized how much work there was going to be, anyway.

The amount of work was indeed a surprise. An unknown factor always, of course, is what the scope of the response will be to one's outreach efforts.

Outreach

Her group prepared a flyer, based on examples she had learned about in the Institute on screening. They also wrote a letter to be sent to families, identified through the census, whose children would be three by June (although the first screening was in May). Through this "census letter" 150 children were targeted.

The May screening presented some timing problems. School vacation week was just two weeks before, and no one would be available during that week to receive telephone calls made in response to the flyers and letters. So the letters were timed to arrive only about a week before the screening. At the same time, posters were put up in stores, nursery schools, health centers, and pediatricians' offices. Advertisements were placed in local newspapers. (Julie regrets that churches were omitted from the outreach program, and she plans to publicize there next time.) People were to respond by telephoning for appointments, which were made for one of two days, a week apart.

Special arrangements were made with nursery schools in the vicinity. Although the screening team could have chosen to visit the preschools, the schools organized car pools instead. In one school:

> what they did was to send one person from their staff with a car and bring several mothers, as many mothers as possible. A couple of children did not come with mothers, but we wanted to see them... the nursery teachers' feelings were that we couldn't see them if we waited for the mothers to bring them in, so... she'd send them down. Mothers in another preschool organized their own car pool.

One referral source Julie expected to hear from never materialized:

> We never, never get referrals from pediatricians. This is going to be a target for next year. We're going to try and run some inservice, where we get some of the pediatricians involved with people in this district over to our school so we can sit in a round table fashion at first and try and establish some kind of communication as to what we do here.

Most frequently, parents referred themselves, typically as a result of receiving the "census letter".

Procedures and Instruments

The core team will always remember the first screening day. As they had planned, 40 children appeared for screening. Unfortunately this was twice as many as could comfortably be handled! Yet all screening had to be done in two days, fewer than Julie feels would be optimal:

> We were unfortunately under constraints from above not to use too many personnel and not to cause them to have too many substitutes to take these people's places, so we were supposed to do it in the least amount of time with the least amount of staff.

Children came with their mothers in groups of eight; that is, eight were scheduled for each hour. Name tags for the children and coffee and doughnuts for the parents—almost all mothers—smoothed the way. There was no way to do one-to-one interviews with mothers. Instead, they filled out the Hainsworth Developmental History Questionnaire, aided by two assistants, while the children moved from station to station by twos—two in gross motor, two in fine motor, two in speech and language, two in hearing and vision.

On that first hectic day, the children, as planned, began by being part of a play group for the social-behavioral observation component. This timing proved unfortunate; the children didn't want to leave their play to go on to the stations. The second time, the play session, complete with juice and cookies, was the last event, a much more satisfactory arrangement.

The screening team decided to utilize separate small rooms in the school basement for the different stations. The large gymnasium used for kindergarten screening seemed inappropriate, since the "acoustics were terrible." (Scores on auditory discrimination had been low in the kindergarten children tested there, and hearing tests had had to be moved to a separate room.) About a dozen staff members covered each screening day.

Although the Summer Inservice Institute provided Julie with useful material on instruments, choice of measures was a main concern. She was able to obtain prepublication outlines of the new Gesell that provided usable norms. Using the Gesell norms, they could tell if a four-year-old was

behaving at the three-year-old level. She and the other speech therapist added some of their own materials, especially for checks of articulation. In addition to the social behavioral checklist provided by the Gesell, teachers added portions of other measures they were familiar with and also focused on particular skills and behaviors they felt were worth extra attention. In the social-behavior observations during the play group, Julie talked with the children, asking them questions about siblings and other topics to get a sample of their language.

One area Julie is dissatisfied with is the hearing and vision screening. (The "illiterate E" is used for vision.) There is no test for color blindness, and the pure tone hearing test, Julie feels, is inadequate to pick up many problems. She and the nurses who do the hearing/vision portion have sought help from state agencies concerned with hearing and vision. They are eager to find measures more appropriate for three- and four-year-olds, and hope to receive training in working with this age group.

After lunch on each screening day, the team met to discuss each child's results, pooling the information they had obtained. Out of the sixty children seen in this first round, screening revealed five children with clearcut problems who were referred immediately for evaluation. Another six children were found to have significant speech and language problems but to do well in other areas; these received speech and language evaluations. Four children needed a recheck of vision and hearing and were asked to come back for a second appointment with the nurse. There were six children who simply could not be screened and who were invited back for the fall screening. All will receive a personal phone call to insure that they do come back, and any parent who is very concerned can request an evaluation during the spring.

Another eight children had very minor deficiencies in only one or two areas. The staff decided to recommend that parents work with these children at home on recommended skill development tasks, which were provided in special letters. Thus, between five and seven children, Julie expects, will require special needs assistance.

Reporting Results

When the team had discussed the results for the children in a particular session, parents were informed of their recommendations. Julie personally telephoned parents of children who needed evaluation or rechecks of hearing and vision. Her colleague, the other speech and language therapist, telephoned parents whose children had speech and language problems requiring special attention.

Form letters were prepared for parents of children who performed adquately in all areas and for those whose children showed a slight weakness in one area; for the latter group, "home remedies" (special help by parents in that area) were to be recommended. The team, therefore, had a variety of form letters: one for "no problems"; one for suggestions about improving fine motor skills; one for suggestions about improving gross motor skills, and so on.

The team unexpectedly found that many parents protested that they wanted to learn their children's actual scores. Knowing that a child performed age appropriately did not satisfy them. Julie and her team are in the process of re-evaluating their approach to reporting results to parents.

Future Plans

In reviewing various aspects of her screening program, Julie feels strongly that having a group of mothers fill out forms at the same time, with coffee and doughnuts available, created a social, relaxed atmosphere that has become a great drawing card. The team had also put various informative booklets on display for parents to take home (on such topics as child development and nutrition) but no one took any! They plan to give packets of materials directly to each parent next time.

Julie is unhappy about the poor turn-out at parent meetings called to explain the screening programs—both those for parents of three- and four-year-olds and those for parents of kindergarteners. She blames inadequate outreach for the poor showing and plans more publicity. Indeed, although regulations currently require parent orientation prior to screening, Julie thinks it

might be better to "have a slide show during our screening process, so the mothers, while they're having coffee, could watch an ongoing slide show that would tell them what was happening to their children while they were here."

Parents were asked to evaluate the screening procedure and provided the team with several helpful suggestions, such as to have rules about smoking and to provide child care for siblings.

In general, Julie thought the screening was effective as good public relations for the schools. Parents seemed pleased:

> I think they felt good about the screening. The feedback that we got was that... they thought we were taking a good look at their children and that, yes, it was a good thing for us to know their children ahead of time.

Intervention Issues

A facet of screening everyone is aware of and concerned about is that one never knows how many children will turn up.

> My Special Needs Director keeps saying to me, "What are we going to do when we turn up all these children?" I said, "It's not my job, it's your job." And he said, "OK, I'm ready to do it then!"

As a result of the screening, the number of children needing the special nursery program is expected to double, and two sessions are thus planned — morning and afternoon. Julie and her boss are concerned about the district's willingness to spend money on bussing children to these programs.

Julie herself has no doubts that spending such money is a good investment:

> It's going to cost them later down the road... If we don't intervene now, we're going to be intervening later, and perhaps if we intervene now, we won't have to intervene later. I don't see why we don't see that.

Julie has become aware that to be listened to, one must talk to administrators about cost and cost-savings, and she now stresses these issues: "The way to their hearts is through their pocketbooks."

Fortunately, in addition to the special needs nursery, the six-town area also contains another preschool with a few funded slots, and there are several parent-sponsored play groups Julie recommends for children who need more experience socializing with peers. In rural districts, Julie feels, such play groups help isolated mothers as well as children.

Julie understands the feelings of some parents who, when a school placement such as the special nursery school is recommended, are reluctant to have the child go to school at such a young age. Their feelings are consistent with her own interest in finding alternative remedial approaches, such as training programs for parents to equip them to help their children in the home setting. Julie had hoped to try out her ideas by running a pilot mothers' group during the summer, but so far she has not been able to do so. As in several other communities, the higher administrative staff:

> has feelings that we are not really responsible for parents... They don't see that as vital — and I do — to the process here. You know, you can do all the language therapy in the world, — it's not even all the language therapy in the world, two 40 minute slots, but when the children leave you, they're going home and they're spending that time with their parents, and if their parents aren't talking to them and stimulating them, it's effort down the drain.

Julie feels fortunate that the District Principal, her immediate superior, is very supportive of these ideas, and she has been writing grant proposals to try to fund pilot program with these approaches to remediation. Too often, however, higher level administrators seem "far removed from the realities of interacting with these children. I don't know why that's the way it is. I guess that's the nature of their job. It's too bad."

For kindergarten children the major issue for placement and intervention is the timing of screening, which occurs in the fall rather than the preceding spring. If the children are identified before beginning kindergarten, Julie points out, they can be placed in the nursery program if necessary. By fall, such a decision requires taking children out of kindergarten and placing them back in the nursery school. Because this is undesirable, children with problems typically are assigned to time slots with the resource room teacher, or, if the problem is visual-perceptual, with a teacher who specializes in that area. Such a solution requires a lot of "running between rooms." And since only three schools have resource rooms, the kindergarten child who needs one has to be placed in one of those schools. Finally, an important service not yet available in the district is physical therapy and adaptive physical education.

Julie thinks a great deal about how to make a real difference in the lives of the children she is responsible for. Children with substantial special needs do get identified and helped in her district. Yet, those with serious problems will most likely have to deal with these problems on a life-long basis. The children she worries most about are those whom early intervention would affect profoundly, and even be truly preventive of later problems, yet who arrive in the first grade still "floundering all over the place".

Julie would find it helpful to have studies based on hard data that support her viewpoint, in order to be more persuasive to district personnel.

THE SCREENER'S ROLE: REWARDS AND CONCERNS

In reflecting about the rewarding parts of her job, Julie finds that she likes the actual work of organizing. Fortunately for someone in a rural district, she likes being an "itinerant", traveling around from school to school. She likes getting to know the variety of schools and towns, to know their "personalities" and learn what to expect in each. The job also fits her because she strongly believes in early screening and in early intervention and values the chance to influence the district's thinking on these issues:

> I believe in knowing the children as early as possible—who's coming down the road—and using that in terms of planning, planning for myself and planning for the teachers.

The main concern Julie has is a fear that haunts her; the fear that 'they're going to miss somebody who needs help," although she recognizes realistically that, indeed, it is inevitable that they will miss some children.

The challenges she faces provide "growing experiences" for herself and other teachers and staff. There are some specific growing experiences Julie hopes to have in the near future—attending an institute in the Gesell, and obtaining more training for her staff in hearing and vision and in perception.

Julie feels fortunate that she attended the Summer Inservice Institute on screening.

> It was wonderful. I didn't know anything about three- and four-year-old screening, so anything I learned was something to learn... There were speech people there, there were psychologists, all different kinds of professionals, and they all came from different districts and different settings. It was interesting to see how they handled things, and I got a lot of good advice from those people... from their models, for example.

She also found valuable the follow-up meetings of Institute participants that took place during the school year:

> We just finished our last meeting, and that was really nice too because it was the day after our screening... I would come in and show them what we'd done... it was really great for support and great, just great, to see what other people are doing elsewhere. We really don't get that kind of contact, unless you go out and seek it on your own... this is sort of organized for you.

In general, Julie is pleased by what she has been able to accomplish and by the attitude of the community: "I really feel good about our school district—that we're taking steps, maybe more steps than other places."

She has no doubt that screening of young children is here to stay. "We've taken that step and we can't go back." The community was impressed with the results of the improved publicity that turned out so many more children:

> Therefore, there was that need and we can't deny it. We can't go back to the previous procedure when only a few children were showing up... We just can't go back there.

COMMENTARY

The five case studies reveal a variety of issues and problems that require comment.

Publicity and Outreach: Who Shall Be Screened?

The phrasing used in outreach materials, and the scope of the publicity campaign, depend largely on how the target population for screening is defined. Communities currently vary in whether they direct their efforts to children with substantial special needs, children suspected of having any problem or delay or all children. Chapter 766 mandates as a target population "those [children] whose parents request such a screening because their children have a reasonable likelihood of having substantial disabilities." Several problems may arise, however, when screening is not available to all children.

Failure to publicize screening as an option for *all* parents means that parents are put in a position of having to pre-screen their own children. This presupposes that parents have had training in what to look for or that they have had contact with a physician or a clinic who has recommended that they attend a school system's screening. Since the majority of physicians in private practices are just beginning to be aware of the links between certain physical conditions and learning impairments and of the fact that early childhood screening can be beneficial to their young patients, parents are as yet only rarely referred through the medical community. Moreover, parents of young children have not had an opportunity to observe their children's performance on the familiar academic tasks of reading, writing, and arithmetic where success of failure would be clearly apparent as a warning of possible trouble. Yet they are asked to determine on their own whether the child has a reasonable likelihood of substantial disabilities! Whole college courses are given on diagnosis of language delay and other problems in young children; parents, however, seem to be expected to be born with that knowledge. Clearly, it would be preferable for school systems to screen all three- and four-year-olds in order to determine which ones are in need of further evaluation and possibly special education and related services. Perhaps only in a situation of infinite financial resources, however, would this be possible.

Financial issues also arise as communities realize that the number of children identified through outreach for screening also affects the number of children who may be found to need services. As communities struggle with budgetary constraints, screeners will need to collect data supporting their belief that it will save money in the long run to identify and serve children early.

Instruments

In some communities where screening programs have evolved gradually and informally, the tendency has been to use "homegrown" measures that lack standardized norms. Screening coordinators new to their positions are often reluctant to make too many changes at once, and many commercially available tests are seriously flawed. The solution too often is to use bits and pieces of standardized tests and to throw in some favorite indices of the screening staff. But items administered out of context cannot be expected to reflect the same norms as the whole unit from which they were taken. Such a pastiche is an inadequate basis for deciding about referral of children for evaluation. Towns should use commercially published tests, which meet appropriate criteria for test construction and norms. An alternative is to use their own measures, if adequate reliability and validity can be attained. In this case they should establish local norms for their own tests and set a cut-off point in scoring to determine on a community-wide basis which children should be referred.

A more specialized problem is the testing of hearing and vision. Three-year-olds can be remarkably uncooperative about tests of hearing. Verbal responses are difficult to elicit, especially from children with language delays, and earphones too often bring out the worst in youngsters. A possible solution is impedance testing, which does not require a verbal response. The child's cooperation is required, but involves only sitting still for insertion of a plastic earplug. Impedance testing directly measures the response of the ear drum to small changes in air pressure; it is particularly useful for detecting middle-ear abnormalities.

Widely used vision tests typically require a child to respond by pointing in a particular direction, as in the Snellen Chart (the "illiterate E" test). Such a method is inappropriate for the youngest age groups; to indicate directionality is beyond the capabilities of all but advanced four-year-olds. Tests that require a verbal response are not suitable for screening children who may have language delays or who may be reluctant to speak. Our current recommendation is that Department of Education personnel work with specialists in the Department of Public Health to develop new methods of vision testing.

A final problem concerns physical examinations of three- and four-year-olds. Regulation 306.1b requires a medical examination as part of the screening process. This presents a series of dilemmas, such as how to pay for the examination, and how to enforce the requirement with parents who are appearing voluntarily for screening. The solution in most communities is to ignore the problem. Parents are not being asked to take their children to a physician as part of the screening nor is a physician made available through the school system. Department of Health regulations currently require a physical examination at kindergarten entry which must be updated before fourth grade, seventh grade and tenth grade. By the time a child reaches age five, however, medical conditions hitherto unrecognized may have done permanent damage (amblyopia, hearing loss, neurological disorders, kidney disorders). It seems to be assumed that children are seen regularly by physicians in their early years, yet even in the wealthiest suburban communities, many are seen only when they are sick and are not taken to the doctor for routine physicals after the first year of life. Therefore, medical screening done when children have their first contact with the public schools would seem to be an essential preventive measure. Cooperation between the Department of Education and the Department of Public Health on this matter might provide ways to carry out this recommendation.

The Role of the Screener

The job descriptions and actual responsibilities of persons responsible for screening are often vaguely defined, resulting in conflicting duties and "overload". Screeners often suddenly find themselves acting as coordinators without having had the opportunity to think out clearly, and negotiate for, their needs with respect to duties, support services, and physical facilities. Currently, screeners juggle conflicting obligations and give up free hours in order to cope with their work load, while struggling with inadequate facilities. As screening programs become more widely accepted and better organized, the screener's role needs to be more adequately defined and the job better designed. A career ladder also needs to be clearly delineated in order to insure the retention of competent professionals.

Methods of Reporting Results to Parents

Methods of reporting results of screening to parents differ enormously, from immediate oral feedback, in varying degrees of detail, to telephone calls, to form letters. Given the anxiety level of many parents, quick feedback seems urgent, as does specific information that goes beyond a pass/fail approach. Reporting is facilitated by careful planning of the testing so that results are shown in an easily understood way. A simple step is the use of paper that automatically creates carbons. We recommend follow-up written reports of screening results, including an invitation to parents to call if they have further questions.

Sharing Solutions

Screeners working individually have arrived at many ingenious solutions and approaches, from providing parents with a tape recorder in order to collect a speech sample from a frightened child, to organizing car pools for transporting children and parents to screening sessions. A major contribution of such organizations as the Early Childhood Project is assistance in generating networks for screeners, who have so little time to develop these themselves.

Utilizing Information from Screening

The case studies clearly indicate the desire of screeners to use information acquired about children during screening to modify classroom curricula, especially at the kindergarten level. Kindergarten screening should not be an isolated event with no relationships to the remainder of the kindergarten program. Screening often reveals children's learning styles, in addition to identifying children who may need help. Utilizing this information in curriculum planning is important to the welfare of screening programs, because teachers often are ambivalent toward screening and evaluation out of fear that a child will be labelled in a negative way and removed from the regular classroom. Actually, information thus gained can help to prevent these negative consequences, as teachers learn to incorporate knowledge of each child and recommend skill-building techniques right into their regular classroom work. Formal as well as informal help in this process — for example, inservice training — would be valuable.

The coordination of remediation between school and home is deservedly receiving increased attention. And since children being screened are often attending preschool, preschools as well as parents can benefit from information about the child's strengths and weaknesses and from specific suggestions for providing help.

Preschools outside the public school system are an important adjunct to following up on screening. Because public school systems can rarely include children without special needs in a preschool program, integrating them with children with special needs will, at the preschool level, require such placement. Fortunately, it is often cost-effective as well as educationally appropriate for a town to pay the tuition required to exercise this option.

Finally, the collection of data relevant to the value of early screening is an urgent task for all those who believe that early intervention may mitigate, or even prevent, problems so disruptive to a child's later school career and personal life.

APPENDIX

INSTRUMENTS

Calibrated Hearing Test Tape (Language Development Program)
Bill Wilkerson Hearing and Speech Center
1114 19th Ave.
Nashville, Tennessee 37212

Carrow Screening Test for Auditory Comprehension
Teaching Resources
50 Pond Park Rd.
Hingham, Massachusetts 02043

Comprehensive Identification Process (CIP) by Reid Zehrbach
Scholastic Testing Service
480 Meyer Road
Bensenville, Illinois 60106

Denver Developmental Screening Test by W.K. Frankenburg and J.B. Dodds
LADOCA Publishing Foundation
East 51st Ave. and Lincoln St.
Denver, Colorado 80216

Developmental Indicators for the Assessment of Learning (DIAL)
by Carol DeMardell and Dorethea S. Goldenberg
Childcraft Education Corporation
Edison, New Jersey

Eliot-Pearson Screening Inventory by Samuel J. Meisels and M. Stone Wiske
Eliot-Pearson Department of Child Study
Tufts University
Medford, Massachusetts 02155

Fluharty Preschool Language Screening Test by R. Weiss
Teaching Resources
50 Pond Park Rd.
Hingham, Massachusetts 02043

Gesell Pre-School Test (to be published Fall, 1979) by Jacqueline Haines, Louise Bates Ames, and Clyde Gillespie
Programs For Education, Inc.
Book Service
Box 85
Lumberville, Pennsylvania 18933

Goldman-Fristoe Test of Articulation by Ronald Goldman and Macalyne Fristoe
American Guidance Service
Publisher's Building
Circle Pines, Minnesota 55014

Goodlite (Symbol) Vision Screening Test
Goodlite Company
7426 Madison St.
Forest Park, Illinois 60130

Michigan Preschool Vision Test
Titmus Optical
Petersberg, Virginia 23808

Preschool Inventory by B. Caldwell
Addison-Wesley Testing Service
2725 Sand Hill Rd.
Menlo Park, California 94205

Preschool Screening System by Marian and Peter Hainsworth
Early Recognition/Internvention Systems
P.O. Box 1635
Pawtucket, Rhode Island 02862